The Obstetric Gazette.

Vol. VIII. — DECEMBER, 1885. — No. 12.

Original Articles.

REMOVAL OF A MULTILOCULAR OVARIAN CYST, WEIGHING SIXTY-FIVE POUNDS. RECOVERY.

By G. W. Boerstler, M.D., Lancaster, O.

Mrs. T., German descent, æt. 44, first menstruated at fourteen, and was married at seventeen; had given birth to fifteen children, fourteen of whom are living, the youngest being three years of age. I was present at this birth, and this was the only confinement at which she ever had the services of a physician; the labor, like her previous ones, was perfectly natural and of short duration; she generally got up in five or six days, and attended to her usual household duties. At the birth of her last child, while making pressure over the uterus to expel the placenta, I discovered the tumor in the left illiac region, then about the size of the fist, and perfectly movable; its presence did not give her any pain nor inconvenience. I saw nothing more of her until about fifteen months ago, when she called at my office for examination. Her abdomen had been gradually enlarging; she was losing flesh and appetite; suffering pain in abdomen, back and legs, and feet and ankles slightly œdematous. The form of the abdomen was symmetrical, and the tumor could be distinctly outlined; movable, and extending up nearly as high as the umbilicus. I advised an operation at once, but she would not consent. I saw her again one year after this, in August, 1885. She had been menstruating every two or three weeks rather profusely; was with much difficulty that she could walk, and many nights she was compelled to sleep setting up in a chair; had almost constant nausea, and frequently vomited her food soon after taking it into the stomach; bladder was extremely irritable, and urination was always attended with pain and burning; emaciation had been progressive, and she now presented the characteristic "facies ovariana." The abdomen seemed distended almost to its utmost capacity, was irregular in form, with distinct elevations and depressions; quite a large, hard mass extended from on a level with, and to the left of the umbilicus, as high up as the ribs; another occupied the left inguinal region, and one in right umbilical region, which was extremely painful on pressure. The abdominal walls were very thin, and fluctuation was distinct in every locality except over the

apparent solid portions of the tumor; the uterus was of normal size, but crowded down and to the right. The following are the measurements then taken: girth just above umbilicus, 59 inches; from umbilicus to cuniform cartilage, 13 inches; from umbilicus to symphysis pubis, 15 inches. She was now anxious for the operation, which I consented to do in a few days. The following night I was called to see her and found her just passing out of a severe chill, with rapid pulse, considerable difficulty in breathing, and suffering acute pain in the upper and left side of abdomen. Hot fomentations were ordered to be kept on constantly, and sufficient opiates given to control pain; the next morning she was more comfortable and the pain had about subsided. I saw that delay in operating would be valuable time lost, and appointed the following morning, Sept. 1, 1885, for the operation. Her menstrual period had just passed. Present: Drs. Goss, Hewitson, Lewis, Nourse, and Palmitor. Squibb's ether was used, which produced complete anesthesia in a short time. An incision five inches long was made in the median line, extending from the umbilicus down towards the pubes; the abdominal muscles were almost obliterated from the long continued pressure of the tumor, and the thickness of the walls did not exceed one-fourth of an inch; there was no adipose tissue; the peritoneum and cyst were intimately adherent, the latter bursting on catching a small bleeding vessel with forceps; the opening into the sac was enlarged, the patient turned on her side, and the thick albuminous fluid rapidly drained off from the main cyst; the other two large cysts were emptied by passing the hand in through the cyst first emptied and breaking through their walls with the fingers. Carefully separating the sac from the peritoneum with the fingers and a steel male sound, I was able to introduce the whole hand and break up the remaining parietal adhesions, which were extensive, and draw the greater portion of the mass out through the incision; the omentum came with it, being firmly attached, and its vessels all much enlarged; this was ligated in sections with firm silk and cut off; broad, flat sponges, wrung out of hot water, were packed into the abdominal cavity, which controlled the bleeding. Another difficulty now presented itself, viz: there was no distinct pedicle that I was able to make out, but the uterus and its appendages with the lower portion of the tumor were all united into one mass, and firmly attached to the whole pelvis; feeling that it would be hazardous to attempt their separation, I cut off the sac evenly and low down as possible, stitched it to the edges of the abdominal incision, put in a large-size glass drainage tube, and closed the wound with silk sutures; adhesive straps, compress of absorbent cotton and flannel bandage completed the dressing.

Although the time occupied in the operation was a little over an hour, there was no great amount of shock, and she became conscious soon after putting her to bed. She took nothing in the stomach during the

first forty-eight hours but iced milk and beef tea, which she relished and retained. On the third day there was a slight discharge of pus from the drainage tube; a warm solution of Liq. Soda Chlorinatum was injected through the tube every four or five hours, and withdrawn with a syringe to which was attached a piece of rubber tubing; these injections were kept up each time until the fluid returned perfectly clear and free from odor. The tube was removed on the seventh day, with most of the stitches; with the exception of the opening where the tube was inserted, and a cup-shaped cavity about an inch in depth at upper part of incision, union was complete. The wound was dressed frequently, kept thoroughly cleansed, and the raw surfaces around the small cavity were dusted over with iodoform. Her highest temperature was 100°, this was on the third day and did not last but a few hours; she never required an anodyne nor the use of the catheter. Before making a professional call, I informed the nurse that I would use the catheter upon my return, but during my absence the patient passed a large quantity of urine without a particle of trouble, so that I deemed it unnecessary to resort to the instrument. On the day after the operation she passed off gas freely per rectum, which added much to her comfort and relief; consequently there was no tympanitis at any time, which is a very annoying and troublesome condition after ovariotomy in most cases, and usually comes on about the third or fourth day. Her bowels were moved freely by a dose of magnesia on the ninth day, and on the twenty-first day she was out of bed. Her recovery was rapid and uninterrupted, considering the size of the tumor and the existing complications.

REMOVAL OF THE OVARIES AND FALLOPIAN TUBES (TAIT'S OPERATION).

Read before the COLLEGE OF PHYSICIANS OF PHILADELPHIA, November 4, 1885.

BY W. W. KEEN, M.D.

Professor of Surgery, Woman's Medical College of Pennsylvania, and Senior Surgeon to St. Mary's Hospital, Philadelphia.

THE following cases are put upon record as a contribution to an important operation, the usefulness of which is assured in certain cases, but the limitations of which have not yet been perfectly well defined:

CASE I. *Uterine Myoma; Excessive Hemorrhage and Anæmia; Tait's Operation; Recovery and Cure.*.—Mrs. L., of New Jersey, æt. 42; married at twenty-eight; two children—the last born ten years ago; each eleven pounds; normal labors; no miscarriages; absolutely well and strong till three years ago, when her periods became more prolonged and profuse. Now she is unwell three weeks out of every four, and the

flow is often so severe as to saturate a napkin every fifteen minutes, besides large clots of blood. She is thoroughly blanched, weak and anæmic.

November 25, 1881. Sent to me for consultation by Dr. Hollingshead. A tumor is visible in the hypogastrium the moment she lies down, and the abdomen is exposed; sound enters six and one-quarter inches. The tumor is an interstitial myoma in the posterior wall, as large as a large fist, moderately tender and painful; no vegetations on the endrometrium; no erosion of os; cervix not involved; uterus movable. Advised Squibb's extract of ergot (*m.* xxx–xl), hypodermically, daily in the abdominal wall for a month; if not then better, advised Tait's operation, as all other means had been previously tried by her attending physician. She was unwell at the end of November, when the ergot was first used. It gave rise to great pain and considerable local inflammation, with nausea and vomiting, and had to be discontinued.

December. Again unwell; the intermenstrual period was freer from pain; but she was weaker and more blanched, and not able to come to the city; lost a large quantity of blood.

January 26, 1882. Came to the city; was so blanched that had she closed her eyes and folded her waxy hands she could easily have been mistaken for a corpse; weight one hundred pounds. Treatment; iron, quinine, milk-punch; food every two hours.

28th. Taken unwell; period lasted until Februrary 2d; used twenty five napkins, besides passing a number of clots. Bad neuralgia of face; morphia (⅛ grain), hypodermically, failed to relieve, but water similarly given lessened it. Eats but little on account of pain.

February 3. Dr. R. P. Harris saw her with me, and concurred in advising the operation. Temp. 98.5°; pulse 80, feeble; heart normal, but weak; no change in uterus.

9th. Operation 12 M.; antiseptic method with carbolic acid including the spray; bladder emptied. Duration of operation forty-five minutes. Ether (fʒvijss) used; incision four inches long in median line from pubes half-way to umbilicus; no vessels tied.

On opening the abdomen a moderate amount of serum escaped. On account of the high position of the uterus the ovaries were readily found. Each pedicle was transfixed with a double carbolized silk ligature close to the uterus, the upper including the fallopian tube, and after ligature the tubes and ovaries were removed. The left ovary showed a recent corpus luteum; it had a few small cysts, and was cirrhosed in part. The right had one cyst two inches in diameter, and several smaller ones. The right tube was cystic just at the cervix uteri; it contained a serous fluid. The veins were very large; no bleeding requiring a ligature occurred. The ligatures were all cut off short. Four deep and

two superficial sutures, the former, including the peritoneum, closed the wound. Dressed with carbolized gauze.

Immediately after the operation her pulse was 120, and feeble. Hot-water bottles were applied, and brandy was used hypodermically several times with good effect. She vomited only once up to 3:30 p. m., when her pulse was 93; temp. 97.2°; very small quantity of food and stimulant every twenty minutes. 7 p. m., pulse 100; temp. 99.6°; has had some pain; feels stronger. 11 p. m., temp. 100.8°.

10th. Slept but little, but is comfortable; temp. 100°.

11th. Temp. 98.4°; considerable pain in the back at 9 p. m. last night, followed by a bloody vaginal discharge. In twenty-four hours has used sixteen napkins, moderately saturated. Water at 105°–110° ordered, which gave great relief.

12th. Has used twelve napkins; temp. 98.8°.

13th. Slept excellently; discharge has ceased; dressing changed (fourth day). It was barely soiled, with very slight oozing from the operation; no pus; wound free from blush; union by first intention throughout; meat allowed.

15th. Several enemata having had no effect, as she felt uncomfortable, the rectum was emptied, mechanically, of a large amount of impacted scybala.

19th. Redressed, wound healed, sutures removed.

22d. Sat up.

25th. The menstrual period was due on the 24th. Has used two napkins to date; less than ʒss blood on each.

March 17th. Went home; weight 110 pounds.

24th. Menstruation due; had some backache; no blood; stayed abed three days.

June 6th. Came to see me; brown as a berry; weight 130 pounds; appetite good; strength nearly regained; each month had had slight malaise; no bleeding; uterine cavity three and three-quarter inches; myoma not perceptible, except by bimanual examination.

March, 1884. Rapidly regained full strength; weight has continued at 140 pounds; no bleeding; sexual appetite unimpaired; tumor entirely gone; uterus three inches.

CASE II. *Severe Nymphomania, leading to Incipient Insanity; Menorrhagia; Tait's Operation; Recovery; Cure.*—Mrs. B., of New Jersey; æt. 42, American; eight children, last born eight years ago; operated on by me, successfully, four years ago for lacerated perineum, and later for severe hemorrhoids. Wife of a poor, ill-paid clergyman, and hence her life was a constant struggle properly to feed and clothe her large family. I have known her from girlhood. She was always a most exemplary Christian woman.

Her head began to trouble her not long after the first operation, and she attributed it to the ether, which, however, she bore perfectly well in both operations. She had strange feelings as if unconscious, and in a fright or dread of ether, especially at night. Exposed to the sun in August, 1881, she had an attack of heat-exhaustion, followed by a second attack a week later. After this her menstruation, always previously easy and regular, ceased for three months. During this time she was treated for malaria, and her head became worse, which she attributed to the quinine. She became very nervous and sleepless; lost all self-control; could not bear any noise of the children, the church-bell, or even her own voice. She became unable to do any work, and had extreme depression of spirits; attempts at suicide were repeatedly contemplated, and though almost determined to end her life, she was deterred by her religious fears. These emotions were readily confessed to me and to her husband. In December, 1882, her menstruation became very profuse, and was continuous for three months. Since then it is not continuous, but is still very profuse.

Meantime, in October, 1881, by spells her sexual appetite, till then a matter of little moment, became immoderate. Day and night it was an exquisite physical and mental torment, and even led her to repeated self-abuse when it could not be gratified. This nymphomania and her head symptoms were always worse at her menstrual period. Finally she went voluntarily to an insane hospital, in March, 1882, being unfitted for her household duties, and in constant dread of suicide; but soon returned home.

January 2, 1883. I saw her; head still as described, and she was almost desperate; uterus normal, except some erosion at os, and freely movable; clitoris and other generative organs normal. Her attacks of nymphomania were still frequent and severe, especially during menstruation. She was fast passing toward permanent insanity. She loathed herself for her abnormal sexual appetite; she had struggled against it, as well as against her suicidal intent, till she was ready to hail anything that gave the faintest hope of relief at any risk to life, for which she cared absolutely nothing. She had been under varied and excellent care, and every moral means and all promising drugs had been freely tried. I therefore proposed Tait's operation, to which she and her husband instantly assented.

4th. Operation; ether; antiseptic method (carbolic acid), with spray; bladder emptied; incision three inches in median line upwards from pubes; layers of fat (she was well nourished) one inch thick, belly-wall two inches. Left ovary found without difficulty; its pedicle pierced by needle with eye in the point carrying a double carbolized silk ligature; ovary and Fallopian tube tied separately and ligatures cut short. One ovarian vein was varicose and as large as the little finger; ovary and

tube both removed. Two pedunculated growths of the size of peas were attached to the ovary, one directly, and another from the middle of a long foot-stalk attached at the two ends to the ovary and to the tissue between the ovary and tube. The right ovary was found with some little difficulty; as it was pulled out of the wound a small cyst burst. It was treated precisely as the left, and tube and ovaries removed. Both tubes and ovaries were intensely congested (her last menstruation was five days past); several small cysts existed in each.

Her recovery was uninterrupted. She had a little bilious vomiting and a retention of urine requiring the catheter, but no pain; and no medicine.

8th. A moderate vaginal hemorrhage began, which ceased four days later spontaneously.

9th, 11th, and 14th. The stitches were removed. Her highest temp. was 99.4°.

19th. Down stairs.

23d. Went home. Since then I have seen her repeatedly; the last time in the spring of 1885. Her mental symptoms and head troubles had gradually become better. For the first six months or more she was often despondent, but she gradually recovered her cheerfulness to a large extent, resumed her household occupations, and is perfectly well. The nymphomania ceased from the time of the operation, save two very slight and short attacks. Coitus is rare, but is entirely normal, and is not followed by any tendency to her former deplorable condition.

CASE III. *Uterine Myoma; Severe and Long-Continued Hemorrhage; Operation; Death.*—Miss W., æt. 40, first menstruated at fourteen, always profusely. For the last seven or eight years much worse, the flow continuing ten to fourteen days. In May, 1884, she began to suffer from continuous hemorrhage, which has persisted till the present date, January, 1885. Occasional severe hemorrhages also occurred. She is very pale and anæmic, with waxy lips, and has lost much flesh and strength, especially of late. To-day I examined her under ether: uterus three inches in length, and movable; a myoma as large as the fist was discovered in the anterior wall and fundus. Hypodermatic injections of Squibb's ergot, in ʒj doses, every second day were used, to which, later, was added ʒj of the fluid extract of ergot daily, with tonics and good diet.

January 29th. Has passed the menstrual period without noticeable hemorrhage, and to-day, for the first time since last May (excepting two days), has dispensed with a napkin. From this date till April her menstruations ceased. In April and May she had a normal discharge. But in June the hemorrhage returned, and continued so profusely as to threaten life.

July 4, 1885. The hemorrhage having been checked for three days

by the above means, I operated. The tumor, which had clearly increased in size, was immediately seen on uncovering the belly. Ether; antiseptic precautions, including the spray (carbolic acid); bladder emptied. The enlarged uterus was so much in the way that the ovaries could not be seized through the small incision first made in the linea alba, the ovaries not having been carried up with it, and it had to be prolonged one inch above the umbilicus. The whole hand had to be introduced, the uterus lifted and pushed forcibly aside, and the ovaries were even then reached with the greatest difficulty, and after several attempts. The ovary and tube on each side were removed, the pedicle being tied with stout carbolized silk, which was cut off short.

The left tube was attached to the ovary at the fimbriated extremity; two cysts, one filled with blood and one with serous fluid, existed in this ovary, the stroma of which was largely cirrhosed. One large (size of English walnut) and one smaller serous cyst were found in the right ovary, and its stroma was atrophied and cirrhosed. All four cysts were ruptured during removal. About eight ounces of serum were found in the peritoneum.

5th. The wound was united with silver wire sutures after careful cleansing of the peritoneal cavity (there was no bleeding), and then dressed with carbolized gauze. Symptoms of peritonitis began to develop, and in spite of all remedies progressed to fatal issue on July 7th. The temperature was 102°–103° till shortly before death, when it rose to 106°.

Autopsy, July 8th. Recent lymph was found over a considerable portion of the belly contents, with an ounce of pus in Douglas's cul-de-sac. No hemorrhage had occurred.

DRAINAGE BY KOEBERLE'S METHOD AFTER ABDOMINAL SECTION.

By R. Stansberry Sutton, M.D., LL.D., Pittsburgh, Pa.,

President of the American Academy of Medicine, Fellow of the American and British Gynecological Societies.

Drainage of the abdominal cavity after laparotomy began with Koeberle, at Strausburg. He first used short tubes, later longer ones, reaching to the bottom of the pelvic cavity, the upper end resting in the lower angle of the abdominal wound. Koeberle taught Keith this method, and the latter continues to use it. Some writer recently stated that Peasley was the first to use drainage, but this is an error. Says Peasley,* "I have not used the glass tube, as first used by Koeberle,

*Ovarian Tumors, p. 512.

since I consider the use of any open tube to be an invitation to septicæmia." Keith introduced the system into Great Britain; from him I learned it.

Drainage is used in this country to a considerable extent, but only a few operators know more than enough about it than is necessary to make their attempts dangerous to their patients. In my last thirty-nine abdominal sections, I have been compelled to drain more than one-third of the cases. This has been due to the fact that the cases were of a very severe character. By drainage, after Koeberle's and Keith's method, I have saved a large number of women, after supra-vaginal hysterotomy who would have died without drainage. In some cases I have thus removed thirty and forty ounces of bloody serum inside of forty-eight hours after operation. To properly drain cases, the following apparatus is required:

1. An assortment of glass tubes in length varying from 3 to 9 inches, and in caliber from the size of a goose quill to the spout of a tea-pot. They should be perforated with holes in the last inch, and the top should be encircled with a flange.

2. A good 4.02 glass piston syringe, four inches of soft rubber tubing to unite the syringe to a celluloid catheter with the bend cut off.

3. Rubber sheets 18x18 inches, perforated in the center with a very small hole.

4. Sponge to place over the end of the tube, to be surrounded in the rubber sheet.

Every possible antseptic care is required to prevent Peasley's fear, viz: septicæmia.

How shall we proceed?

My method, deducted from observations made a few years ago at the operations of Koeberle and Keith, is as follows:

On the table, at every operation within the cavity of the abdomen, the entire drain apparatus is in readiness. It is all submerged in an antiseptic fluid. A tube is placed in the lower angle of the wound reaching the bottom of the pelvis. It is secured by a suture above it. After the wound is all closed the rubber sheet is adjusted over the tube, the sponge is placed upon the mouth of the tube, and the rubber sheet is folded about it. All is secured with the binder.

At intervals of three or four hours during the first day, and six hours in the second day, the tube is emptied by suction with the syringe and catheter. As soon as the serum loses its red color the tube is removed.

The longest time I have had a tube in was 56 hours; it was in the case of a lady who recovered after I did double ovariotomy for cystic ovaries and supra-vaginal amputation of the uterus at the same time. She was brought here by Dr. McClure, of Suterville, Westmoreland County. She was operated on, March 28, 1884, in my private hospital;

she is still living in good health, or was very recently, when I saw one of her neighbors who knew her and spoke of her to me.

The cysts were developed under the broad ligaments, the latter roofing them, and the uterus was so involved that everything had to be renewed. In another case of the same character, done successfully and drained, I was able to leave the uterus. In one of the cysts there was a hole, and the cavity of the abdomen contained over sixty pounds of fluid secreted by the leading cyst. In a case sent me by Dr. Findley, of Altoona, in which I removed, by supra-vaginal amputation, the uterus, with large fibroids, this method of drainage not only saved the case, but made it easy.

But it was not my object to give or multiply cases; we have used drainage in a great many, some of whom recovered entirely by reason of it. Used properly, safely, viz: with great cleanliness, it is a great method of safety, but it will admit of no carelessness or dirty measures in dealing with it. Following Keith's methods in operating, viz: the cautery clamp for the pedicle, and drainage, I have had patients recover who would have undoubtedly died by any ordinary methods of operaing them.

With drainage, Baker Brown's treatment of the pedicle, and my precautions in regard to sepsis,* high temperatures are rarely seen, and for more than two and a half years I have not seen a drop of pus in a wound which I have made in the abdomial walls.

A Curious Mistake.—The following anecdote is related as an actual occurrence. A young man fresh from college, whence he came with honors and medals, was sent by his father, a practitioner of fifty years' standing, to attend a woman in labor. On making a digital examination, he found the os uteri undilated. After waiting an hour, there being no improvement, he applied belladonna ointment, and endeavored to make forcible dilatation. At the end of another hour there was still no dilatation; and being alarmed, he sent to his father for assistance, but before they returned the child was born. On examination, the father found that the child's anus was red and patulous, and was liberally besmeared with belladonna ointment. The young practitioner had met with a breech presentation, and had mistaken the child' anus for an undilated os uteri.

The OBSTETRIC GAZETTE and Cincinnati *Lancet and Clinic* to one address, one year, $5.00.

* See Cincinnati *Lancet and Clinic*, Oct. 31, 1885.

Society Reports.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, October 1, 1885.

The President, B. F. Baer, M.D., in the Chair.

Dr. Wharton Sinkler read a paper on

The Different Forms of Paralysis Met with in Young Children.

The most frequently met form is infantile spinal paralysis or *poliomyelitis anterior*. This term indicates the pathology of the disease, which is an inflammation of the nerve cells of the anterior horns of the white matter of the spinal cord. This affection may come on at any period in life, but is generally seen in children, and usually at the age of ten years. The children are generally strong and apparently healthy, and the paralysis is sudden in its onset. Fully two-thirds of the cases I have seen have been attacked in the summer months, hot weather and teething seeming to be predisposing agents. Dr. Barton, of Manchester, Eng., reports that of fifty-three cases in which he noted the time of onset, twenty-seven occurred during the months of July and August. The attack is preceded by fever of greater or lest intensity, with pain in the head and limbs, with general soreness when moved or lifted. After a few days paralysis more or less complete occurs, but in a few days a regression of the paralysis from some of the afflicted parts occurs. Sensation is undisturbed. Atrophy of the muscles is soon apparent, in fact, the paralyzed portion stops growing for a time. The temperature of the affected portion is low and the skin is blue and mottled, but there is no tendency to ulceration, and wounds or scratches heal readily. The skin and tendon reflexes are lowered or abolished in the affected limbs. At first response to the faradic current is last, but later on the galvanic current produces but little muscular contraction, except when a powerful current is used.

When atrophy has set in the reaction of degeneration is seen. Most of the cases of club-foot are the result of infantile palsy. Deformities of the upper extremities are rare, this disease differing in this respect from cerebral palsies.

The exact causes of infantile palsy are unknown. Overfatigue often precedes an attack; sudden chilling is considered by Seguin to be a frequent cause.

The prognosis as to perfect recovery is only moderately good. In many cases the most faithful treatment fails to relieve the paralyzed muscles, but in almost every case we can expect more or less improvement.

In the early stages of the paralysis, after the subsidence of the fever, the treatment should consist of mild stimulation of the spine; ergot and small doses of bromide of potassium should be given internally. Later in the disease iodide of potassium should be given instead of the bromide. When the palsy is established, electricity and massage are the means to be depended upon. They must be persisted in for months, or even years. Internal treatment is of little or no value unless there is some failure in the general health of the child.

Spasmodic Paralysis, as seen in children, is of two varieties. When of primary spinal origin, or when there is a descending degeneration of the cord from a primary cerebral lesion. Sometimes there seems to be a congenital defect in the motor tract of both brain and cord. In the spinal variety there is often seen, soon after birth, rigidity of the limbs; at first this is only occasional, but as the child gets older every effort to move a limb causes muscular rigidity in it. The child does not attempt to walk until three or four years of age. Then, when it is supported under the arms and tries to stand or to walk, the movements are very peculiar and characteristic. The feet are extended and inverted, so that the child rests on the toes. The knees are strongly adducted and lock together, so that the legs become entangled. By degrees the child becomes able to walk by the aid of apparatus or some form of crutch. The hands and arms are often affected, and every effort causes muscular rigidity to come on. The mind is unaffected in these cases, and the speech may be distinct, although it is often very defective. Sensation is unimpaired, and the patella reflex and ankle clonus are exaggerated. There is no wasting of the muscles.

By these symptoms we infer that the disease is localized in the lateral columns, but exactly what is the nature of the lesion we do not know, for no post mortem examinations have been made in these cases. The cause is unknown. Hamilton found three of seven cases which he had collected were premature births; adherent and contracted prepuce has been thought by some to be caused by reflex influence of the spasmodic paralysis, but operation has not given relief.

The treatment should consist of massage, galvanism of the spine, ergot and cod-liver oil. Fluid extract of conium may be given to allay spasm. In some cases great improvement follows this treatment.

Even where we can do no particular good to the limbs. very much can be effected by the aid of apparatus. Properly adjusted braces to the legs will enable a child to walk on crutches or in a Darroch wheel crutch.

There is a form of spasmodic spinal paralysis in which the child is imbecile. In these cases there has probably been congenital defect in the cerebral development. The head is small and there is no evidence of intellect. Often mystogenesis is present.

Paralysis from Pott's Disease. — Paralysis of the lower extremities may

result from caries of the spine. The lesion may be either a meningitis or a myelitis. If meningitis alone, there is considerable pain and contraction of the legs. Generally there is a transverse myelitis. The symptoms are numbness and pricking of the legs, with loss of sensation; gradually increasing loss of power, with wasting of the muscles; incontinence of feces with retention or incontinence of urine. Sometimes there are ulcers over the sacrum or on the limbs.

The indications for treatment are evident. An apparatus which will take the weight of the body from the spine is necessary, and is sometimes sufficient of itself. Frequently, however, the employment of the actual cautery over the spine brings improvement in the symptoms when an apparatus has done no good. Massage and electricity should be used to restore the atrophied muscles.

Paralysis from Rachitis and Diphtheria is seldom complete. The former is often spoken of as the pseudo-paralysis of rickets. Negro children, who are very subject to rachitis in cities, often have rachitic paralysis. The child at three or four years, is unable to walk or stand. Sometimes it has not sufficient muscular development to sit upright. It can move every limb and has no loss of sensation, but has no power. Cod liver oil and massage bring about the most satisfactory results in these cases.

Diphtheritic Paralysis usually begins in the muscles of the soft palate and pharynx, and extends to the extremities. It is generally bilateral and incomplete, but I have seen a case in which it was hemiplegic. It is considered peripheral in character, and is believed by some to be connected with the altered condition of the blood consequent upon the original attack.

Diphtheritic paralysis is rarely fatal, and lasts in most cases only a few weeks, although it may continue for months. Strychnia and electricity are the means to be employed, and the case usually responds promptly to these remedies.

Pseudo-hypertrophic Paralysis is a rare affection, but is of much interest. The disease belongs almost exclusively to infancy. It is characterized by muscular paralysis with great increase in the bulk of the muscles. This enlargement is due to fatty deposits while the muscular tissue proper is atrophied. The affection begins with weakness of the legs, a peculiar balancing of the trunk, and separation of the legs in walking. The shoulders are thrown far back in standing and walking. There is great difficulty in getting from a sitting to a standing position. Later in the disease the muscles become wasted and shrunken and the general health begins to suffer. Death results from implication of the respiratory muscles.

The skin is mottled like a piece of castile soap. The tendon reflexes are abolished and electro-muscular contractility is impaired. There is often a greater or less amount of mental weakness. There is no loss of

power over the bladder and rectum, and sensation is not affected. Heredity influences the disease, which is slow in its progress, but the course is steadily downward.

Frederick's Disease is still more rare than the preceeding. It is practically locomotor ataxia in childhood. Here is evidenced also a hereditary disposition, and the female children seem most liable.

Cerebral Palsies.—Hemiplegia may result from some injury at the time of birth, either from the forceps or from the pressure of a prolonged labor. A child may be born hemiplegic after a perfectly natural and easy labor. Under these circumstances we must regard the paralysis as the result of imperfect cerebral development. Hemiplegia under these circumstances is generally permanent. The side affected grows less rapidly than the other. The flexors of the arm and hand are usually contracted. The leg becomes rigid in the act of walking.

Convulsion is almost always associated with cerebral paralysis, either immediately preceeding the attack or occurring soon after. The convulsive movements are most violent on the side which is subsequently paralyzed. The child will have an idiotic expression and speak indistinctly, but their friends think them intelligent.

The convulsions are liable to return when the child is older, and then assume an epileptic form. The walk is peculiar and is called the *spastic* gait. The patient plods along looking as if he were about to pitch forward. The affected limbs are smaller and shorter, the growth of both bone and muscle being affected. In the choreic variety, where the arm is in constant motion, the muscles may become hypertrophied, but the bone remains short.

Prognosis.—As a rule, the prospect of recovery is bad, even if the patient gets well the hemiplegic side remains awkward.

Treatment —Cod liver oil and massage, which always relaxes the contracted muscles. The affected limbs should be used as much as possible.

DISCUSSION.

Dr. Harris inquired if Dr. Sinkler had ever observed any hereditary predisposition to convulsions and cerebral paralysis.

Dr. Sinkler replied that the hereditary influence was decided, even if no convulsions occurred.

Dr. R. P. Harris read a report of the autopsy upon Mrs. Reybold, from whom two living children had been removed by

CESAREAN SECTION

by Prof. Gibson, of the University of Pennsylvania. The superior strait was reniform; conjugate diameter 1¾ inches, transverse diameter 5¼ inches. The malformation was due to rachites and injury from a fall in her second year. A full report of the history of the patient, the opera-

tions and the autopsy can be found in the *American Journal of the Medical Science*, October, 1855, p. 422.

OOPHORECTOMY.

Dr. E. E. Montgomery reported the following case: Mrs. L., of Columbia, Pa., *æt* 36 years. Married ten years; pregnant five times, the last four years ago; was brought to my notice by Dr. A. F. Chase. Her health has been bad since her last confinement. First menstruation at twelve and a half years, regular and very free for one and a half years, when she fell, producing pelvic distress, after which for seven years the flow was very scanty, lasting but one or two days and accompanied by excruciating pain. She improved somewhat after marriage. Her first conception was followed by so much nausea, vomiting and anemia, that her physician advised and induced an abortion.

She is now regular as to time, but irregular as to quantity; it is preceeded by an excruciating pain for two days and continues until the flow disappears; she also has severe pain in the head. She is very nervous at all times, but this is much intensified during the period. Pain is more marked in the left inguinal region and down the corresponding limb. Coition and vaginal examination are very painful. The uterus is enlarged and painful, tender on pressure over both ovaries. Local uterine treatment had been kept up during the entire four years, with no relief. Trachelorraphy had been performed. Ovariotomy was advised. September 19, 1885, she entered my private hospital and, assisted by Drs. W. H. and C. B. Warder and E. Eshleman, the uterine appendages were removed. The left ovary was composed of a number of cysts, the largest of which ruptured while adhesions were being separated. The right ovary was not enlarged, but it was removed to insure relief. The wound was closed with silk gut, and dressed with sublimated gauze and absorbent cotton. There was no shock. The highest temperature reached was 101.6° at midnight of the 20th, and it became normal on the 22nd. Sutures were removed on the eighth day, and the wound redressed for the first time. It had united throughout and there was no irritation from the sutures. The effect upon her general health remains to be determined.

Dr. Montgomery also reported a case of

SUPRA-VAGINAL REMOVAL OF THE UTERUS AND BOTH OVARIES FOR FIBROID TUMOR.

Ann U., *æt* 27, was brought to me by Dr. T. H. Boysen, of Egg Harbor City, with the following history: Her menses from the beginning occurred every three weeks, and were free an entire week. During the last four years they have occurred every two weeks and are attended with pain in the pelvis and down the limbs and severe pressure upon the bladder, causing frequent urination, and several times necessitating the use

of the catheter. Dr. B. had diagnosticated fibroid tumor, which my subsequent examination confirmed. The tumor was the size of a child's head, filling up the pelvis and apparently arising from the anterior wall. The examination led me to believe that the bladder was adherent over the anterior surface and would render the removal of the tumor unsafe. I suggested the removal of the ovaries. She entered my private hospital September 9, 1885, for that purpose. Drs. W. H. Warder, Boysen, and Martin assisted, Drs. C. B. Warden and Staltweather present. An incision three inches long was made, and finding the tumor free from the bladder, with cervix sufficiently long to serve for a pedicle, the incision was extended to within an inch of the umbilicus above, and symphysis below, and the tumor, with some difficulty, withdrawn. In the absence of a Tait's clamp, which had been ordered some days before, the pedicle was constricted by a wire-ecraseur, and the tumor, with the ovaries, was removed. The pedicle was then transfixed with two steel pins, and tied in three sections with strong silk thread. The peritoneum was fastened to the pedicle, below the ligatures, and the wound closed with silk-gut sutures; the pins holding the stump outside. The wound was dressed with sublimated gauze and absorbent cotton. The operation was followed by some shock; temperature 97.4°, pulse 104, from which she soon rallied. She complained greatly of pain. A half-grain of morphia had been given by suppository and three hypodermatic injections of morphia, ¼ grain each, were given during the afternoon, before the pain was relieved.

At three A. M., of the 24th, I was called by the nurse, who reported bleeding from the stump. Three ounces of blood had been lost. By aid of Dr. Warder, a Wells's clamp was applied below the pins, apparently controlling the hemorrhage; but it recurred later in the day, from the angles and from beneath the clamp. By this time the Tait's clamp had arrived, and the patient was etherized, the lower three sutures removed, the pedicle drawn up, the clamp applied so as to control it completely, and the wound again closed. The wound had united throughout. Temperature reached 100.9° at 9:30 P. M. The highest subsequently, 101.6°, was in the afternoon of the 25th, and it became normal on the 28th. Upon removing the dressing, on the 27th, some pus welled up about the pedicle. As the skin was irritated, the dead pedicle was cut away until the clamp slipped off. There resulted, of course, considerable retraction of the stump, but the sloughed tissue is now nearly cleared away. The patient suffers no pain or discomfort; temperature normal. The tumor was situated in the anterior wall and fundus of the uterus and projected into the uterine cavity.

Dr. Parish remarked that removal of the ovaries had given such good results in cases of uterine fibroids, and was comparatively so free from

danger, that he would like to hear from Dr. Montgomery his reason for his choice of operation.

Dr. Montgomery replied, that the tumor filled the pelvis and pressed upon the bladder and rectum, causing great and constant distress. As diminution of the size of the fibroid tumor is not a certain result of oophorectomy, and as all the circumstances were in favor of the major operation, he decided upon it as the best one.

Stated Meeting, Thursday, November 5, 1885.

The President, B. F. Baer, M. D., in the Chair.

Dr. John M. Keating read the following paper on

SYMPATHETIC LEUKÆMIA IN CHILDHOOD.

The short paper which by invitation I propose to read to you this evening will, I am sure, prove of interest on account of its clinical rarity, and the infrequency with which we meet the disease in current literature. To make the subject more interesting and more lucid, at the risk of recalling to your memory matters already familiar, I will premise with a few remarks on the blood in health in children, and briefly, with its diseases.

There is an uniformity of composition of healthy blood which is curious. This is brought about by the equilibrium which is so striking in textures which are regulated by the production and waste.

The blood corpuscles which we are called upon to study are, 1st, *the red*, of which there are floating in the plasma about 5,000,000 to the cubic millimetre. These are about 1-3200 of an inch in diameter. 2d, the *white*, of a diameter of 1-2500 of an inch, having the proportion of 1 to every 300 or 500 red. 3d, the nucleated red found in the fetus and infant, and disappearing about the third or fourth year of life. These may contain one or more nuclei protruding from the cell. They measure from 1-1400 to 1-1200 of an inch. 4th, the *hematoblasts* of Hogen—"small, discoid, colorless corpuscles, normal constituents of healthy blood. — in drawn blood they aggregate in clumps known as Schultze's granule masses." As the origin of red corpuscles I will quote: "they are developed from colorless corpuscles, the lymph cells or leucocytes. The nucleated corpuscles in the embryo also aid in the development. These nucleated cells disappear early in childhood, and are then found only in the red marrow." It is Osler's opinion that "they apparently originate from colorless marrow cells which gradually become more homogenous, and hemoglobin develops in the protoplasm, the nucleus degenerates and disappears, when the cell has the appearance of an ordinary red disc." Possibly these nucleated cells may give birth to red cells by the process of budding. The relations of the cystogenetic organs to blood formation has always been a somewhat debatable ground; the present state of our knowledge may be formulated about as follows: "The spleen certainly

takes part in the development of colorless corpuscles, but its participation in red blood formation is more doubtful; though the opinion prevails widely that the spleen is one of the important organs in the formation of red corpuscles, the evidence for this belief is of an exceedingly scanty nature.

The lymphatic glands and adenoid tissues in other regions are the seat of constant production of colorless corpuscles, but of their relation to the red corpuscles there is the same lack of information as in the spleen."

Neumann and Bizzorzio pointed out the fact that the red marrow appears to be the seat of blood formation. In the adult it is the only region in which embryonic or nucleated red cells are found. In the young the marrow fills the long bones.

It is Osler's opinion, and I have quoted from his recent admirable articles on this subject, that the evidence of the development of red corpuscles in the marrow rests upon the constant presence of enucleated cells infiltrated with hemoglobin and of their fission. In excessive hemorrhage, natural or induced, it appears to undergo active proliferation, and it is an interesting fact to notice the marvelous rapidity with which the red corpuscles are reproduced after a hemorrhage. The amount of hæmoglobin in healthy blood, according to Preyer, is 13·45 grammes to 100. This relation is important for us to have in mind, as it proves an index to treatment. The color test being used, I feel certain that before long it will be a matter of more than ordinary interest to the general practitioner when the means of applying the color test shall be generally adapted as has been done already to general practice.

In the newborn the blood is said to amount to 1-10 part, by weight, of the body; in the adult, 1-12 to 1-14. I may also note that it has been shown by Neumann that the liver in the embryo may be the seat of the formation of corpuscles, though in the adult it is the seat of their destruction.

Let us now take up the subject of anæmia in children. Were I to attempt to do justice to this condition, it would take far more time than your patience would allow. We will omit that caused by hemorrhage, by toxic agents, by mineral poisons, by miasm, by syphilis, in which we have an increase in the watery elements and a diminution in the albuminous, and consider that dependent upon disorder of the blood making organs themselves, and here we meet with a most difficult problem. By the blood making organs we understand the spleen, the lymphatic tissues and the bone marrow, remembering of course that some of these tissues have also to do with blood destruction. We however definitely know that an increase in the cystogenetic tissues is associated with disturbances in blood formation. The organ undergoes a hyperplasia, particularly in its fibrous constituent, and the marrow of bone changes from normal ap-

pearance to one like spleen pulp. The blood of all patients suffering from anæmia presents a reduction in the number of red corpuscles. This is true no matter whether the seat of trouble is located in the spleen, the marrow of bone or in the general lymph glands, the white cells may or may not be increased. The clinical features of a case of anæmia will be strikingly alike; let the cause be in any one of the blood making organs, all the more important symptoms will be present. To quote once more, such common features would be "the progressive anæmia with its group of circulatory symptoms, the irregular febrile reaction, essential fever of anæmia, the absence of marked emaciation, the tendency to effusions of serum, the progressive debility, the recurrence of hemorrhages, gastric and intestinal; gastric and intestinal disturbances, and the resistance to treatment."

These affections that have so many symptoms in common are grouped as distinct diseases under the following headings, viz.: Leukæmia, Hodgkin's disease, (anæmia lymphatica), splenic anæmia and idiopathic anæmia.

Leukæmia signifies a hyperplasia of the blood making organs, with anæmia and an increase in the colorless corpuscles. Of this form we have three varieties, the splenic, lymphatic and medullary. Leukæmia is present at all ages, the youngest case recorded by Osler being an infant of eight months. The chief symptoms are insidious onset, anæmic appearance, bleeding at the nose or other hemorrhages, frequent diarrhœa or other gastro-intestinal disturbance. The spleen is enlarged, gradually increasing in size from the onset, and finally it may interfere with the circulation and cause difficulty of breathing by pressure. Late in the disease the liver is also enlarged. The lymph glands in most cases are affected and sometimes slightly enlarged. The tonsils and follicles of the pharynx are usually enlarged. The lymph glands of the intestines and of the peritoneum are always enlarged. Fever is present and increases as the case progresses, and is usually of the remittent type. But the most important aid to differential diagnosis is the microscopical examination of the blood. This I give in detail in the case that forms the basis of this paper, which I will now relate.

I was called in consultation by Dr. I. W. Gadd of this city to see the child with him in the latter part of last month, and the following notes were given by Dr. Gadd:

Mamie McC., aged 4 5-12 years, had measles when about two years old, from which she recovered without complication or sequelæ. About August, 1884, the tissue surrounding the eye became much inflamed and swollen. The swelling increased so much that the eyelid could not be opened for several days. After continued poulticing an abscess formed and broke, discharging a quantity of pus, and continued to do so for some time, but finally healed up with a small scar. The child never

complained, but was pale and did not want to play as other children did. I believe this was more due to her disposition than to the effect of any disease.

About midsummer there appeared a rash all over her body, very thick, and resembling the eruption of measles. As it matured it was crowned by small white caps or heads. The epiderm soon came off in large patches. The child had no fever. As the eruption faded, the mother observed purplish spots like bruises making their appearance. These were considered by the parents to be bruises due to falls. No attention was paid to her condition until Sept. 28th, when I was called in the evening to arrest an epistaxis which had existed most of the day. I found the child lying on a sofa, though able to sit up, with blood slowly trickling from the nose, each nostril contained a large clot. The child appeared very anæmic, with slight fever, yet did not complain of anything except weakness. The mother stated that the appetite had been very poor for some time past. The bleeding from the nose was very easily arrested by removing the clots and packing with a strip of lint in each nostril. I also gave the following internally:

℞. Acid gallic gr. xxx.
Acid sulph. dil. ♏ xl.
Ext. ergot fl. ♏ xxx.
Syrupi ℥ i.
Aquæ q. s. ad. ℥ ij.

M. et sig., a teaspoonful in water every hour. Also ordering her as much milk as she cared to take, with the precaution that she should sip it slowly.

Tuesday morning I saw her and found her in the same condition, with the exception that the epistaxis had been arrested. I thought it best not to remove the lint packing. It now being daylight, her mother called my attention to the bruise-like spots over her body. They were in size from that of a two cent piece to that of a fifty cent piece, and two of them, situated one over each trochanter, were as large as silver dollars; with the exception of these two, I believe they were all situated over the soft parts, such as over the belly of a muscle, and varying in color, according to age, from a bluish-black to a greenish-yellow. She still had some fever, and her heart was more rapid in its action than normal, hence I gave her, in addition to the gallic acid and ergot mixture, the following:

℞. Liq. potass. cit. ℥ i.
Spts. aeth. nit. ʒ ij.
Tr. aconite rad. gtt xv.
Syr. Limonis ʒ iv.
Aqua q. s. ad. ℥ ij.

M. et sig. Teaspoonful every two hours.

Wednesday morning I found her feeling somewhat better, though still having slight fever, pulse 124 per minute and moderately weak in character. I did not detect any abnormal heart sounds. I removed the lint packing without any further bleeding, and with much relief to the patient. I then ordered tr. digitalis in three-drop doses every three hours, and also the following:

℞. Quin. sulph. . gr. xiij.
Tr. ferri citro-chlorid. ʒ i.
Syr. tolu ℥ i.
Aqua ʒ vij.

M. et sig. Teaspoonful every three hours.

Thursday I found the patient, to use her own language, well; evidently much better. Fever had entirely subsided, the heart's action remained abnormally rapid. The cervical glands were slightly enlarged, but no enlargement of the tonsils and apparently no inflammation of the fauces. Treatment was continued, with the addition of more nourishing food, beef tea, wine, whey, etc. The child seemed so much better that I said it might come to my office the next morning instead of my going there. Later in the same evening she took a sudden change for the worse, but I was not sent for until Friday morning. Now the patient was suffering from high fever, 104° F. in the axilla, pulse 134 per minute, compressible. The cervical glands much enlarged and very hard; the bowels had not been moved for twenty-four hours, the tonsils were but slightly swollen, there were no patches in the throat. Thinking that possibly she was developing a malignant form of diphtheria, I at once put her on the calomel treatment until the bowels were moved, giving her three grains, repeated in two hours, and then two grains, when the bowels were moved freely and the calomel was stopped. I also gave suppositories of two and a half grains of quinia every two hours, also

℞. Liq. ammon acet. ℥ i.
Spts. æth. nit. ʒ ij.
Syrupi ʒ iv.
Aqua ʒ ij.

M. sig. Teaspoonful every two hours.

I continued the tr. digitalis in five-drop doses every three hours. I also applied hot flaxseed poultices to the enlarged glands, and at noon plenty of beef tea and milk, but the child did not care for food, and it was difficult to get her to take any nourishment. At mid day I noticed for the first time, although I had carefully and frequently listened before, a systolic heart murmur. The temperature was but little affected during the night, and next morning (Saturday) at 7:30 I found it as high as ever, 104° F. on the axilla. Fearing that endocarditis had set in from the continuance of high fever and the heart pressure, I at once applied a mustard plaster to the pericardium, followed by a poultice, giving inter-

nally potassium iodide and ammonium carbonate, continuing the digitalis until noon, when I met Dr. J. M. Keating in consultation.

Physical signs showed, in addition to what has been mentioned, an enlargement of the spleen, yet there was no history of malaria. Dr. Keating did not think that endocarditis had set in, believing the murmur to be rather of a hemic character, yet as a stimulant to the heart suggested the application of a blister, internally, very small doses of Basham's mixture every three hours, with the free use of alcohol, beef juice in small amount, etc., the temperature to be kept down to 102° or lower by means of the wet sheet. On examining a specimen of the urine which had just been passed, and the first that I had been able to obtain, I found it to be of sp. gr. 1016, of a light straw color, free from albumen and sugar. The child could not retain either medicine or beef juice. The nose again commenced to bleed, to prevent which I again plugged the nostrils. Soon large clots of coagulated milk were vomited, the result of having been given in half cupfulls at a time, which was entirely contrary to my direction. Her stomach soon became settled and she took brandy and crushed ice in small quantities. We wrapped her up in a wet sheet and then poured cold water over her until the temperature came down to 101° in the axilla, which required about 35 minutes. She was then wrapped in a blanket. In two hours the temperature was again 104°. We gave several of the wet packs during the afternoon and evening, and notwithstanding we were at the same time giving 2½ grains of quinine every hour by suppository, the same rise in temperature was observed after each. During the night she took her medicine regularly. Alcohol and water and beef tea were also administered.

Sunday morning (the day of her death) I found her to all appearance bloodless, pulse rapid and small, respiration shallow and too frequent, temperature rising to 104° after the wet pack as before. During Saturday night she had removed the packing from her nostrils, which allowed a slight oozing of blood, and this having been swallowed gave rise to vomiting of clotted blood; these continued, after the bleeding from the nose had been again checked, and gave me the belief that there was a slight hemorrhage into the stomach. These clots differed somewhat in size and color from those which I ascribed to the epistaxis. The heart became more rapid, 138 per minute, and the patient gradually sank. She died at 6:30 p.m., in great agony, giving two or three shrieks which were quite loud considering her weakened condition.

Dr. Keating remarked that Dr. William Osler had kindly examined for him a slide of blood and reported as follows:

"Report on slide of blood sent by Dr. J. M. Keating. Examination about three hours after withdrawal.

"*Red corpuscles* present no special alteration in size or shape.

"*Colorless corpuscles* greatly increased in numbers 50 or 60 in each field

of the No. 7 Hartnack. They present remarkable variations in size, many are small, not more than one-third of the larger forms; they resemble the smaller colorless cells which Virchow has noted to be present in cases of lymphatic leukæmia. Many of the cells have feeble amæboid movements.

"*Nucleated red corpuscles* not observed.

"*Schultze's granule masses* (often abundant in leukæmia) scanty."

The relation of the increase in number of the colorless corpuscles above noted to the increase in size of the glands and cystogenetic tissue is indeed hard to solve. The increase in size and hyperplasia of the spleen in leukæmia and anæmia are histologically identical. We must remember that the view that colorless corpuscles are changed into red corpuscles is not fully established, hence also it is not proven that the excess of colorless corpuscles is due to failure in the change to red ones. In such cases the prognosis, when the disease is detected at its incipiency, may be favorable under rigid treatment of fresh air, suitable diet, iron, quinine, and arsenic and salt bathing; but in marked cases that have existed for some time, with advanced symptoms, the result is fatal.

DISCUSSION.

Dr. Goodell inquired if there was any distinguishing points between perpura hemorrhagica and lymphatic leukemia. If there is a deficiency of red blood corpuscles, why do red patches occur so easily?

Dr. Keating remarked that the subject under discussion was dependent upon certain conditions, which physiologists are still debating. In leukemia we have as a diagnostic feature an involvement of the lymphatic system more or less, a hyperplasia of the tonsils, lymphatic glands of peritoneum and of the intestines, also of the spleen and bone-marrow. All of them being more or less connected with the red cell formation; but the principle diagnostic point is the increase in number of the colorless cells, as is noted in Dr. Osler's report just presented. The hemorrhages in these cases are possibly due to a diapedesis or capillary rupture. In what is known as purpura hemorrhagica there is an exudation of blood cells or the hematin from their destruction into the reta mucosum and the papillary layer of the cutis, of course capillary ruptures may occur with profuse hemorrhage. The blood cells (red) are usually diseased, they become enervated, or they cease to form rouloux and possibly the plasma may be at fault. The miscroscope alone will reveal the distinguishing features. Purpura may be considered a symptom accompanying a dyscrasia in which the blood itself is involved, not merely the organs of its production.

Dr. William Goodell exhibited the ovaries from two cases of oophorectomy with the following histories:

Oophorectomy for Ovaralgia.

When the patient, an unmarried woman, aged 30, first consulted him, she weighed 236 pounds, but at the same time she was very weak and could barely walk. She suffered excessive pain at her catamenial periods, which appeared only at long intervals. She had cataleptic and hystero-epileptic fits, and complained of very constant and acute ovarian pains. Her urine was passed but once a day, and this act was attended with much suffering. The womb was enlarged and the ovaries were very tender indeed, but nothing else abnormal was discovered. Assafœtida and the bromides were prescribed in large doses, and she was advised to try the rest treatment.

Fourteen months later she was again brought by her physician to consult Dr. Goodell. She now weighed only 120 pounds, having lost 116 pounds, and she was in every respect worse, her ovarian pains being now constant and very acute, requiring large doses of morphia to control them. Her catamenia had not appear for nearly four months, and tonics seemed to have no effect whatever on her. Her physician was compelled to be in constant attendance on her, and was liable to be summoned at any hour of the day or night to give her a hypodermic injection. Masturbation was suspected, but she always denied practicing this habit. Nothing further could be done than the operation of oophorectomy, which was accordingly done a few days later at the hospital of the university. The ovaries were found much enlarged from cystic and interstitial degeneration, but there were no evidences of peritonitis or of cellulitis, which had been suspected. A corpus luteum existed in one ovary. A rectal hemorrhage or vicarious menstruation having taken place a few days before the operation. Her ovarian pains at once left her; she needed but very few doses of opium, which were given by rectal suppositories. Her convalescence was prompt, and she returned home in less than four weeks, free from all pain in a fair way to get perfectly well. The case was a typical one of the advantages of oophorectomy. Yet he (Dr. G.) thought that the operation was being performed altogether too frequently.

Oophorectomy for Bleeding Fibroid of the Womb.

In this case the lady was 37 years of age, and had been married eleven years. She gave birth to a child about seven years ago, and since then has had one premature birth at seven months and one miscarriage. She first noticed an abdominal tumor nine years ago, but her catamenia began to be free some time before this. Late in the year 1881 the catamania began to be excessive. As nothing seemed to check them, early in the following year Dr. Goodell was consulted. He found multiple fibroid of the womb. Six tumors could be readily made

out, of which two seemed pedunculated. The sound gave a measurement of 4.5 inches. Under ergot and ammonium chloride the patient improved for several months, then the menorrhagia became worse, and finally a dribbling of blood kept up between the periods. In May of the present year she again consulted Dr. Goodell. She had been dribbling continuously from January, and was much reduced in strength. Being a brunette, she exhibited the facies uterina in a most marked degree, the pigmentation being very dark and extensive. The womb now measured 7.5 inches. She was admitted into Dr. Goodell's private hospital, and May 24th both ovaries were, without difficulty, removed. They were greatly enlarged by follicular degeneration, a condition which Dr. G. had repeatedly seen in cases of fibroid tumor. The effect of the operation on the tumors, and especially on the main one, was astonishing. After two weeks this fibroid had diminished in length nearly a hand's breadth. Her recovery was prompt, and she was sent to Atlantic City to recruit. On July 10th, just forty-seven days after the operation, she called on Dr. G., who found the tumors very greatly reduced in size, and the uterine cavity measuring only 3.25 inches, a diminution of 4.25 inches. This extraordinary amount of diminution, in spite of the fact that the obliteration of the ovarian blood-vessels cut off only a small portion of the blood supply to the womb, drove him to the conclusion that the ovaries were the important factors in inviting blood to the womb. Every successful cure in which he had removed the ovaries for fibroid tumor of the womb had been followed by the menopause and by rapid diminution in the size of the tumors. But in his hands and in those of others this operation was more fatal than that of ovariotomy. During the ten months of the present year he had had twenty-five cases of ovariotomy with but one death, and that one in a lady operated on at her home, two hundred miles from Philadelphia. For simple cures of oophorectomy the mortality should not be greater than that of ovariotomy. But when complicated with the presence of a large or an adherent fibroid tumor, the operation is often one of great difficulty. Twice during the past year he was unable to reach the ovaries and was compelled to abandon the operation, because in neither case was the woman willing to undergo the risk of having hysterectomy performed. Each case recovered, and while the women were under observation the tumors appreciably lessened in size, as if the shock of the exploratory incision had temporarily suspended the ovarian influence.

Dr. Montgomery was glad to hear the good results in Dr. Goodell's cases. In a few of the cases upon which he had operated the menopause did not at once occur, sometimes not for two years after the operation. In such cases the tumor did not decrease in size, while menstruation continued. In the case of hysterectomy for fibroid tumors, reported by Dr. Montgomery at the last meeting, the temperature at no

time exceeded 101.6°, and the patient left the hospital to-day perfectly well. He preferred removal of the uterus and its appendages entire when the ovaries cannot be removed in consequence of previous inflammatory changes. Ligation of blood vessels supplying the tumor might be useful when nothing better could be done.

Dr. Baer thinks that when the ovaries can be removed it is the preferrable operation.

Dr. Goodell has been so uniformly successful in removing the ovaries for the cure of fibroid uterine tumors that it is his choice. He has been notified that in a case of fibroid tumor of the womb in a woman aged 33 years, he will be called in consultation; this will be the third. He will advise removal of the ovaries; if, at the time of operation, that is not found possible he will close the incision as the other operation is very dangerous, and the patient can certainly live a few years as she is. In one case only of his oophorectomies has the menses continued, and he thinks in that case there must have been some supplementary ovarian tissue.

Ovariotomy.

Dr. Montgomery exhibited for *Dr. Warder* a large ovarian tumor and related the following history: The patient was a young woman. Her menses commenced at 17 years of age, and had always been irregular. They ceased entirely for twelve months, and at the same time the abdomen was enlarging until the tumor reached above the navel. Fluctuation was doubtful; the mass seemed quite solid and pressed the uterus down into the pelvis. Anæsthesia did not relax the abdominal wall, and diagnosis was doubtful. An exploratory incision, showing the pearly tint of an ovarian tumor, made it sure. Nothing would pass through the trocar, but some of the jelly-like contents of the tumor escaped beside it and passed into the abdomen. The large cyst was filled with small cysts. The patient did well for one week, then the pulse became rapid; but she has since been doing well, and is now rapidly recovering.

Dr. Goodell thinks the danger from the escape into the abdomen of cyst contents is overrated.

Dr. Baer: In the early stage of ovarian tumors metrorrhagia is sometimes present; sometimes the menses are entirely absent. He should like to hear from the society some reason for this inexplicable difference.

Dr. Goodell has observed the same facts, but can throw no light upon it.

Dr. Montgomery remarked that in this case both ovaries had undergone cystic degeneration. The second ovary contained numerous small cysts.

Dr. Baer inquired about the treatment of the second ovary.

Dr. Montgomery replied that it was removed.

Some Uses of Cocaine in Gynecology.

Chas. Herman Thomas, M. D.:—Seldom does a new drug reach so sure a place in the confidence of the medical profession as that accorded to cocaine. I early began its employment in ophthalmic practice and soon extended its use to a variety of gynecological applications. The results obtained have been so satisfactory that I now never go to such a case without cocaine in my bag or pocket. After considerable experience in its use I am convinced that it is quite as valuable in the latter case as in the conditions for which it was originally recommended. That it is a local anesthetic when applied to mucous surfaces is a familiar fact, but its property of reducing inflammation and engorgement of the same class of tissues is not so generally recognized, notwithstanding that is a point of considerable practical importance. This action of the drug is readily verified by observing the marked paleness and shrinkage which follows in a few moments after its application to surfaces thus affected. While this condensation of tissue is to a considerable degree temporary, it seems to be of longer duration than the accompanying anesthesia. In some cases the good results obtained by reducing hyperemia in this manner appear to be permanent. The common fear that it will fail to prevent pain may usually be overcome by placing a few drops of the solution on the tip of the patient's tongue, when the numbness produced seldom fails to induce full confidence in its efficacy. Cocaine Hydrochlorate is the salt upon which my experience is based.* A four per cent. solution grs. ijss. to ʒi in water acts well for most purposes, though a somewhat weaker or stronger one may sometimes be substituted with advantage. The addition of boracic acid in the proportion of grs. ij to the ʒj insures sterility of the solution.

When used it should be applied with thoroughness, the parts being first freed from mucous and some minutes allowed to elapse for its effects to develop; the time should be *not less than two minutes*, and in cases where considerable pain is to be anticipated, a strong solution, 10 per cent. or more, may be employed and the application repeated after an interval of two minutes, and in five minutes from the beginning the full effects of the drug may be looked for. That the anesthesia produced by cocaine is complete, I have personally experienced having made use of a four per cent. solution by injection into the nostrils previous to an application of the galvanic cautery to the nasal cavity. The cautery had been applied on a previous occasion without cocaine and the pain was severe. With it not the slightest pain was felt, and I was conscious of the action of the cautery only by the hissing sound produced.

I have found it particularly valuable in certain cases of cervical en-

*The price has been reduced to 10 cents per grain, or less.

dometritis, in which, though there may be no evasion externally, and but little characteristic discharge, there is a state of extreme sensitiveness existing about the region of the internal os-uteri, a probe or cotton easily bringing blood, and any application made to the part is liable to produce bleeding and severe radiating and ovarian pain. Cocaine carefully applied with the syringe or the cotton-carrier prevents the pain and bleeding which would otherwise follow the necessary medicinal application. The swelling being also materially reduced, the congestive or inflammatory stenosis, which usually exists, is consequently for the time relieved and applications to the part itself, as well as to the entire endometrium, are greatly facilitated.

In urethral caruncle sensibility may be so destroyed that the painful excrescences may be clipped off and the site painlessly cauterized. Cocaine is also extremely useful in painful irritation and inflammation of the female urethral tract and especially of the part just within the meatus, a condition attended with distress frequently referred to the bladder. Appropriate medication is painlessly made after its application, which may be conveniently made by means of the glass medicine dropper. As a means of preparation for the operation of stretching either the urethra or cervix uteri it is of unquestionable value.

To precede the application of caustic to a chancre it is also effective.

I am informed by my friend, Dr. Levis, who has had large experience with the drug, and who uses it extensively and with great satisfaction, that plastic operations upon the vagina, where considerable surfaces are to be flayed, the cocaine anesthesia is insufficient to prevent pain.

It has been recommended in dysmenorrhœa, and there is good reason to believe, from several reports which have been made, that it is capable of producing excellent results when applied to the os-uteri and to the cervical cavity by means of a small cotton tampon. I tested it recently in a case of uterine colic, using it hypodermically, in two doses of one grain each, about half-an-hour apart, but without appreciable relief.

It has been tried internally, in doses of one grain or more, in the vomiting of pregnancy and has met with some favor, but in the only case within my own knowledge it entirely failed.

In a case of vaginismus, brought me by a practitioner from a neighboring city, the condition was quickly relieved by the local application of cocaine and a complete examination was easily made, when without its use general anesthesia would have been necessary.

In a case of hyperæsthesia of the vagina, with mild vaginismus, in which frequent local treatment was required, a suppository containing one grain of cocaine introduced into the vagina a half-hour before each treatment entirely abolished the spasm, and rendered the introduction of the speculum easy and comparatively painless. Cocaine suppositories

also produced excellent results in a case of rectal tenesmus after opium had proved insufficient.

Cocaine has been recommended in operations for lacerated cervix, and for the crushing of stone in the bladder. I have not made use of it in either of these applications, but strongly believe in its value.

In one hyperæsthetic patient, in whom violent pain was developed on slight provocation, and who required local treatment of the cervix uteri and urethra, but who suffered so much from ordinary applications that the local benefit was fully counterbalanced by harm done nervously, it became necessary to suspend treatment on this account. After cessation for six months, treatment was resumed under cocaine, and it has since been in every way satisfactory. The pain formerly produced by applications to the cervix being now entirely absent. In the same patient painful irritability with spasm of the bladder simulating cystitis, which was not entirely relieved by the opium suppository and other measures, yielded completely, and thus far perma ently, to a single injection of one grain of cocaine thrown into the bladder. The resumption of treatment in this instance was largely due to the enthusiastic approval of the husband, who had himself experienced complete relief from the injection of one drachm of the four p. c. solution into the deep urethra for a violent urethrismus. In another instance, in a woman with irritable piles, red as a ripe strawberry, and who was suffering extreme discomfort, the piles shrank and turned pale under the cocaine application and were then painted with tincture of iodine with entire absence of pain.

Dr. Keating has used cocaine for some time in the same class of cases. He now uses eight per cent. solutions with great success, especially in childrens' throats. He employs salicylate of cocaine in diphtheria in a five or six per cent. solution, sensibility disappears in a short time and he can then use any application without discomfort; he applies carbolic acid, tinct. of iodine, etc., in this manner without exciting pain. He also applies cocaine before injecting carbolic acid into piles and also applies it on cotton to prevent its action ceasing too soon.

Dr. Thomas said that the strength of the solution may, with propriety, be greatly varied, and that in his practice upon the eyes even a one per cent. solution was strong enough to be of considerable value in conditions of irritation produced by foreign bodies in the eye; but in other cases, as urethral caruncle, it might be well to use it even in saturated solution.

The question of strength is largely a question of expense, for in local application no toxic results are likely to be produced.

Don't neglect to give the baby a drink of water once or twice a day. The nursing baby cries oftener from thirst than hunger.

BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

First Regular Meeting, held November 10, 1885.

Dr. George W. Miltenberger read a paper on

Version and High Forceps.

A purely practical question, which has long divided obstetricians, and upon which there does not as yet seem to be a universal agreement among them, and which should be, if possible, definitely settled, is as to the best course to pursue when artificial delivery is demanded in the interest of mother, or child, or both, when the head is still free above the upper strait aud movable, or when delivery is urgent, when the vertex has partially entered the strait, but has not yet engaged, and readily recedes under pressure by the fingers, or as soon as we attempt to apply the forceps.

Of course we have here but the alternative; steadying the head from without by abdominal pressure and then applying the forceps, or version.

In the first place, we have to call into consideration the difficulty of readily and properly grasping the head, even when thus held, thus high, and while we know that it can be done and is done, we equally well know, that, at times, it is not by any means facile. In the second place, when thus seized and at this point, when the whole of the transit through the pelvic canal is to be affected by this *vis a fronte*, we equally well know the dangers to the maternal structures, with the best and most appropriate instruments, and here the Tarnier in some of its modifications, should be used, and with the best tactile skill and experience. In the the third place, we are equally well aware, that to avoid the second danger time is required, and the descent of the head must be gradual, while the safety of the child may also thus be endangered, while with version in skillful hands, we have the delivery of the child completely under our control, as soon as we have seized and brought down the foot or feet. If we look at the general statistics in relation to the child, as to the results from version, it is very true that we are met by a picture not at all re-assuring, but on the contrary laid down in colors so dark as to cause us to hesitate before resorting to it, whenever it can properly be avoided. Thus at the clinique de Paris (*Depaul*) in the years from 1852 to 1880, both included, there were 172 cases, the mortality to the mother being 13.95 per cent., children 50 per cent.; but a considerable number of them were brought into hospital after various manœuvers had been previously tried, and mother and child thus seriously compromised. (*Charpentier.*)

Zweifel gives the mortality of internal podalic version at 8 per cent. of mothers, and 58.9 per cent of children.

Madame La Chappelle puts the infant mortality at 1 in 3.96.

Carus, Osiander, Kiwisch, Michaelis return it as 1 in 2; Ricker loses 1 mother in 10; Hueter 1 mother in 14; and Churchill in 542 versions places the mortality of the infant 1 in 3 and mother 1 in 15. This is unquestionably a frightful record, but we must bear in mind the fearful accidents which render the operation necessary in a great majority of the cases, including, besides trunk presentation, hemorrhage, eclampsia, rupture of the uterus, certain presentations of the face, prolapse of the cord, cases of monstrosity, dystocia caused by tumors, contracted pelvis, etc., while we all know personally and practically its almost absolute safety, when time and opportunity can be well chosen, as in those cases of which we speak, when the head is moveable above the brim, and the uterus is not so contracted as to hold the head fixed at the strait. The chief dangers to the mother are:—nervous shock, which may be entirely left out of consideration with the use of a stimulant and chloroform, which should always be employed, and which is as likely to occur with forceps; rupture of the uterus or other mechanical injury, but little to be feared, save when the waters have long been evacuated and the uterus strongly contracted upon the child, and not then unless undue force is employed, and here they do not fall in this category; and septicæmia from the introduction of the hand. But in this case, I do not see that there is really any difference between the introduction of the hand and the introduction and application of the blades, and if there be some slight difference, the anti-septic cleansing would be as sufficient in the one, as in the other.

If we take merely general forceps cases, on the other hand, we find them not free from danger.

Poppel in 102 cases without complications, gives a mortality of 11 per cent. for children, and Spiegelberg, in his own clinic, where the forceps are applied only when strongly indicated, gives his mortality in children for 5 years, 17 per cent.

Siekel of 6,228 infants extracted by forceps, gives 1,069 lost between 16 and 17 per cent. In 6,685 forceps cases, 184 mothers died, nearly 3 per cent.

Murphy's table of 248 forceps cases, gives a mortality of 20 mothers, and of 50 children.

Harper's table (forceps) gives us:

Collin's fœtal mortality	1:26;	Maternal	1:329.
Hardy	"	1:20;	"	1:334.
Johnston	"	1:30;	"	1:502.
Harper	"	1:47;	"	1:1490.

These included all cases.

We have no statistics of high forceps alone, which must be much worse.

Such is, it is true, in the majority of these reports, very widely differ-

ent from our results in private practice; and in addition we are perfectly well aware of the unsatisfactory character of statistics in obstetrics. We know nothing of the special character of the cases, we are of course ignorant of the details, we are not informed of the time or the mode of operation in the given case, nor most frequently of the methods or skill of the operator, while in many of them the subjects have been brought into the hospital after having been submitted to various, and it may be, to crude and prolonged or repeated manipulations. But still there are the same sources of distrust and error in both these sets of cases, and in all probability the errors in one will offset those in the other, rendering them at all events approximately true for purposes of comparison.

I have intentionally merely mentioned in the one and the other operations those dangers incidental to the manipulations themselves, and liable to follow in the hands of those best supplied and most skilled.

I have purposely omitted those, which the advocates of one or the other method may say, do not occur in their hands, and are but the result of want of cultivated skill on the part of the operator.

These are for high forceps:—Injuries to maternal parts due:

1. To direct pressure of the widely separated blades during traction.

2. To pressure of the fœtal head, which we are attempting to drag through the pelvis, it may be, in a faulty position.

3. To slipping of the blades.

4. To inclusion of some part of the maternal tissues in the grasp of the blades.

In version, besides those mentioned, metritis and peritonitis, very infrequent and usually preventible accidents. As to the child, we are all aware of the possible dangers in version, from forced extraction, if we at once follow the one with the other, and equally aware of the means of avoiding such dangers.

In high forceps we meet with abrasion or contusions of the face with facial paralysis, swelling and ecchymosis of the eye, etc., more lasting injury to scalp or face resulting in sloughing or abscess, indentation or fracture of the cranial bones, lesions of brain substance or intracranial hemorrhage, due to compression of the head by the forceps or against the pelvic bones, or the above mentioned fracture of the skull, possible pressure upon the umbilical cord and consequent asphyxia of the child.

As to the difficulties of the operative procedures, they should not, it is true, be taken into consideration if circumstances demand one or the other, but as merely incidental there is no comparison between them.

Version, in the cases mentioned, is simple and easy, while the high forceps, if the head is movable above the brim, demands and exacts the highest and most cultivated skill on the part of the accoucheur, and if applied skilfully, handled judiciously and the object accomplished successfully and safely for mother and child, at once stamps his rank and position.

Now let us examine the opinions of operators, and the weight of authority. One of the first, if not the first, to apply the forceps in this position was Smellie, as was perfectly natural after his great improvement of the instrument and the consequent extension of its field of usefulness.

He was followed in this by Solayres, Deleurye, Courtouly among the French, and Baudelocque somewhat later gave full rules for the operation, without however concealing the difficulties that underlay its performance.

Moreau says: "Smellie was the first to recommend the application of the forceps to the head when it was still above the superior strait. This operation is difficult and dangerous, therefore it appears to us that the cases to which it is applicable are very limited in number. We reduce them to two:

1st. When there is a moderate contraction of the pelvis; but the child being above, the forceps should never be applied if the antero-posterior diameter is not at least three inches and three-quarters in length.

2nd. When the pelvis is well formed *but version is impossible*, because the liquor amnii having been discharged for sometime the uterus embraces closely all parts of the fœtus."

Madame Le Chapelle says (*Cazeaux*): "An application of the instrument upon a head which is still above the superior strait is both a difficult and dangerous operation. Difficult:

1st. Because its elevation renders the diagnosis of the position obscure, and often leaves us operating in the dark.

2nd. From its mobility it escapes from the forceps, and not unfrequently it is merely held by the points or margins of the blades, so that as soon as any resistance is met with from the first tractive-efforts it slips out just like a cherry-stone when squeezed between the fingers, and

3rd. Because at this height it is impossible to apply the blades on the sides of the head, since the latter is usually found in an oblique or transverse position.

Dangerous, because the hold on the head being very imperfect, in consequence of the difficulties just enumerated, the instrument may slip; and should this slipping take place while we are making strong traction on the handles, the edges of the forceps, acting like a cutting instrument, might seriously wound the cervix."

Cazeaux says: "If the head be but little or not at all engaged at the superior strait version would be preferable, unless the pelvis was very narrow, or the womb so firmly contracted as to render the introduction of the hand unusually painful or even impossible."

With this Simpson agrees.

Hodge distinctly asserts: "The *fixation* of the head and its partial projection through the superior strait seem to us essential pre-requisites for the operation of the forceps."

Chailly lays down the same rule.

Leishman says:* "But in some cases (in which we may assume the pelvis to be of normal dimensions) the operation of turning will generally be preferred."

Parry: "Many prefer forceps to version even when the head is movable, but the difficulties are so great that many prominent authorities practice version in preference to employing forceps under these circumstances."

Playfair concludes: "If the operation be attempted before the head has entered the pelvic brim, it must be fixed as much as possible by abdominal pressure."

R. Barnes, 1879: "In lingering labor, when the head is resting on the brim, the liquor amnii discharged, and it is known, either by exploring with the hand or by other means, that there is no disproportion, or only a slight degree of disproportion, even although the cervix is not fully dilated, the forceps will generally be better than its alternatives, *i. e.*, expectancy, ergot or turning."

Lusk insists: "So long, indeed, as the head is movable at the brim, and version is practicable, the latter operation furnishes the safer mode of delivery." 1885.

Charpentier sums up: "The majority of authors agree in preferring *version* to *forceps* in all cases where this is possible."

Verrier says, 1884: "The forceps *may be applied* above the superior strait," and with this Pajot coincides.

Schroeder lays down the rule: "Whilst the head is still movable above the brim version is easy, and this should always decidedly be preferred;" and he goes further and declares, under the head of contracted pelvis, that "a gentle attempt at turning is always harmless and often succeeds when the head is apparently impacted, thus affording the best chance for mother and child."

Naegele, 1872, says: "We (German) obstetricians discountenance the forceps in these cases altogether."

Zweifel says: "When only a small segment of the head can be felt in the pelvic brim, *i. e.*, when the entire head still remains above the small pelvis, the operation of high forceps is altogether out of the question (should not be considered), and this opinion fully accords with and is but the reiteration of that of other experienced obstetricians." Here he advises version.

Zweifel lays great stress on the fact that version and extraction are entirely separate and distinct operations, and do not necessarily go together as antecedent or consequent, unless the circumstances of the case require it. This must be considered in estimating the dangers of version. "In

*Leishman, p.490. Edition, 1874.

the obstetric clinic we have often been able to demonstrate cases where the fœtal heart-sounds, which immediately after version were very weak and slow, have after a while become stronger."

I have been induced to bring this subject before the society from having had within a comparatively short time two cases illustrative of the points I have presented, not with a view of laying down the law or of determining the question by my dictum, but merely to open for discussion a subject of so much practical interest.

Mrs. N.; multipara. In two previous labors forceps had been demanded. There was slight antero-posterior contraction, which, however, had previously permitted a natural delivery. After a somewhat prolonged labor, the mother's condition required relief, the head being but partially engaged in the superior strait. Forceps were applied, Hodge and Simpson in succession, and although the instrument held and did not slip, the most powerful traction which I thought justifiable failed to engage it fully. Forceps were removed, hand introduced, head receded readily and without effort, version and extraction followed. Mother and child were both saved, and no difficulty during puerperium.

Mrs. S.; multipara. After a tedious labor, mother and child both, I thought, demanded prompt delivery; vertex presenting, but movable above the strait; pelvis normal; head large, as verified after birth. Placing her in position, I found upon attempting to use the forceps, even with abdominal pressure from above, that I had difficulty in applying them satisfactorily, and feared in the first place, lest they might slip, and in the second, that with the requisite delay for safety, the child would be lost. I withdrew the instrument, passed in the hand, turned and delivered promptly, and safely for both. Puerperium uninterruptedly good for mother and child.

A case which caused me much regret at the time and since, was that of Mrs. B., multipara, some years since, in which, after severe and exhausting labor, the head still above the brim, I applied in succession Hodge, Simpson and Tarnier, and securing a firm and unyielding hold with last, exerted my whole power, without being able to bring down or thoroughly engage the head. I then waited for an hour and a half for further natural efforts, when I succeeded with the forceps, but the child was still-born. I was convinced at the time, and am now, that if I had resorted to version previous to the use of the forceps, or directly after my first failure with them, I would have saved the child and have relieved the mother that much earlier. This caused me the more regret, as it was one of only four still-born children I have had the misfortune to meet in ten years. The other three were, one of presentation of the brow and two breach presentations in primipara, where the waters were evacuated early, and where, after dilatation of the os, complete in one case, partial in the other, the most determined manual efforts were required for their extraction.

DISCUSSION.

Dr. P. C. Williams said it was very difficult to speak upon a paper that was so full and covered so much ground as that to which we had just had the pleasure of listening. It was also very embarrassing for him to be compelled to differ from one whose ability and experience enabled him to speak with an authority that very few members of the Society could command. He said his own experience, though very limited as compared with that of Prof. Miltenberger, compelled him to differ with him in the choice of methods when the head was still unengaged in the superior strait of the pelvis. The statistics quoted seem very formidable, but most of them express the experience of practioners prior to the general use of anæsthetics and of Tarniers' forceps, and we all understand the difference this would make in our choice of a method. But Dr. Miltenberger's statistics did not correspond with his (Dr. Williams) experience and that experience had taught him in most cases to prefer the forceps to version. After the membranes are ruptured version is rendered much more difficult in all the cases demanding interference and in such cases experiencé had taught him to prefer forceps. Again, the child may be of normal size and the pelvis abnormally narrow; or the pelvis normal and the child abnormally large. In either of these cases the Doctor would choose forceps rather than version, especially since the introduction of Tarniers' forceps, for the reason, that, to his mind, version does not change the relative proportion of either the child or the pelvis, whereas the forceps may and do more or less compress the head and thus diminish the disproportion. In those cases where the disproportion is considerable, version is certainly very difficult and if we fail to deliver we have greatly increased the difficulty of applying forceps or of performing craniotomy, if such a proceedure should be demanded. Experience has shown him that axis traction, as applied by Tarnier's forceps, greatly facilitates the delivery.

Did time allow, he might give cases illustrating these points and showing that in his hands forceps are more easily managed than version. After all in many cases the choice must be decided by each man's own experience and with the facility with which he performs either method. One man has acquired facility in the use of forceps while another finds version more easy to perform. Either would find his judgment greatly influenced by his previous training and the facility with which he operated. He had acquired facility in the use of forceps and therefore, under ordinary circumstances, would be inclined, by habit, to resort to them, as the proceedure which had hitherto proven successful in his hands. From the paper we had just heard read, we learned that Dr. Miltenberger's experience with version had been remarkably favorable and therefore he naturally inclined to that method of delivery.

Dr. Williams also said there were various other points to which he

would like to call attention, but that he felt he had already spoken longer than he ought.

Dr. Miltenberger, in reply to Dr. Williams, said that his paper dealt with cases of normal pelvis and heads, or those in which the heads were but slightly enlarged. When the head presented by the vertex, the base of the triangle presented, while after version the bi-mastoid or the shortest diameter of the head and the child could more easily be stripped through, and that since first proposed by Simpson, this had been almost universally recognized.

Dr. Thomas Opie said he considered that the introduction of axis-traction forceps had created a new era in obstetric practice, and had changed the relation between version and forceps. There were certain cases in which version was to be preferred to forceps viz: in occipito-posterior positions in posterior, positions of the face whether at the superior strait or in the excavation, in placenta prævia and in antero-posterior contraction of the pelvis to 3¼ inches. In other cases he would give the preference to traction-rod forceps. He agreed with Dr. Lusk's view, that the old Tarnier blades are best adapted to securing the head above the brim. He ordinarily uses the Taylor narrow blade forceps, which will go through an os measuring one and a half inches in diameter, to dilate with in cases where the Tarnier blades cannot be introduced. The method of turning by bi-manual effort, the hand in the vagina but only two fingers inserted into the uterus, as suggested by Braxton Hicks, is worthy of imitation. Of course his choice of methods was controlled by the peculiarities of the individual case, but taking all in all he used forceps in the greater number of cases.

Dr. W. P. Chunn in reference to the subject, mentioned a case which he had recently seen in consultation, in which the patient had been in labor for three days, and had lost a great deal of blood on account of a placenta-marginalis. The head was high up and the uterus soft and flabby. In this case he delivered with forceps because he thought it could be done more quickly than by version.

Dr T. A. Ashby remarked that there were two strong arguments in support of the operation of version in these special conditions referred to in Professor Miltenberger's excellent paper. The first was to be found in the fact that the operation of version had been so simplified by the method of Braxton Hicks, that it was no longer the formidable proceedure, as in past days. Version may be accomplished with comparative ease by the combined method before the escape of the amniotic fluid. After this, its employment is attended with greater difficulties; still the writer of the paper had reported several cases where version had been accomplished within a uterus emptied of its liquid contents.

The second argument was based upon a well known doctrine, advocated by some of the best obstetric authorities, to wit; that when version

failed the forceps could still be resorted to, whereas, after an attempt to deliver with forceps and a failure, the operation of version would be undertaken under most unpromising conditions. He thought that, in those cases when the head was freely movable above the rim, versian was an easier and more preferable method of delivery than with the forceps.

Dr. H. P. C. Wilson said that, in the class of cases mentioned in Dr. Miltenberger's paper, he would turn every time. He had failed repeatedly with forceps and succeeded afterwards by turning and he had lost children by depending on the forceps, that he felt certain he might have saved by resorting to version earlier.

Dr. W. T. Howard said whether version or the forceps is to be preferred in the interest of the mother, or the child, or both, when the head is movable above the superior strait or when the vertex has partially entered, but has not become engaged in the strait, is a very complex problem. Its solution, as it seemed to him, depended upon such a variety of circumstances and conditions that no hard and fast line can be drawn between the two; and that each case, therefore, must, in practice, be decided for itself. All things considered, Dr. Miltenberger thinks that, in such cases, there is no comparison between the two, and that while version is simple and easy, the successful use of the forceps demands the exercise of the highest skill. Still, he admits, and indeed proves by a long array of statistics gathered from the writings of a large number of eminent obstetricians in different countries, that version is attended by a mortality to the child so frightful, that we should hesitate to resort to it whenever it can be properly avoided. And, on the other hand, the statistics adduced prove that the mortality to the mother by version is much less. Thus, to cite only a few of the cases Dr. Miltenberger has brought before us: while Depaul, in the Paris Clinique, found that in 172 cases, the mortality to the child by version was fifty per cent., to the mother it was only 13.95 per cent. Zweifel gives by version a mortality of 58.0 per cent. for the child, and only 8 per cent. for the mother. And Churchill, in 542 versions, places the infant mortality at one in three, and to the mother at one in fifteen. It is clear, then, that, according to these statistics, version is an operation greatly to be preferred in the interest of the mother, and obviously to be shunned in the interest of the *child*, if the forceps gives the latter a better chance for life. What, then, does the forceps present in the interest of the child? In 102 forceps cases, Poppel gives a mortality of eleven per cent. for the child, and Spiegelberg in his clinic during five years an infant mortality of seventeen per cent. It seems to be equally clear that the forceps gives the child a better chance for life than version. These statistics, however, are not derived from high forceps operations, of which Dr. Miltenberger says there are none, but he infers that they must be much worse. That however, depends upon the kind of forceps used and the skill of the operator.

But what chance for life does the forceps offer the *mother*? In 6,685 forceps cases Sickel states that 184 mothers died—nearly three per cent. only. And I may add that Dr. George Johnson, of the Dublin Lying-in Hospital, applied the forceps in 113 cases before the head had passed out of the os uteri, not only to save the life of the child, but also to prevent much danger to, if not the death of the mother from the effects of long-continued pressure on the soft parts, and without a fatal result to either mother or child. Of course, this demanded exceptional skill: but it shows what a conservative instrument the forceps is both for mother and child, when in the hands of men of large experience and the highest skill. And it proved to Dr. H.'s mind that in the hands of such operators the forceps offers a better chance for life both for mother and child, in many cases at all events, than does version, and especially for the latter. Dr. H. admits that when the head is free above the brim, the cervix easily dilatable and the membranes unruptured, version by a skilled hand may be readily accomplished, and that the danger to the mother may not be great. But the danger to the child must be greater than that from the forceps in equally skillful hands. It is often said that when, in version, the feet are drawn through the os externum, the case does not involve greater risk to the child than in an original feet presentation. If this be admitted, pedalic version involves greater risk to the mother, as in head-last labors demanding rapid passage through the os (always badly dilated in primiparæ in manual delivery) of an uncompressed head, the cervix is prone to be lacerated; while on the other hand, fenestrated forceps with small blades, under chloroform may be often so used as actually to prevent cervical laceration. With one or two fingers of the left hand, carefully and slowly draw the anterior lip forward toward the vulva, or press the cervix over the head, while with the right hand, traction is intermittently and judiciously made in the line of the pelvic axis. But the infantile mortality in all pelvic presentations whether natural or artificially made, is universally admitted to be much greater than in head presentations. In the former the risk to the child is so great as to be estimated by able obstetricians at one in three. Dr. H. well remembered how vividly the late Professor C. D. Meigs used to impress upon the class at the Jefferson Medical College the importance, in such cases of having the forceps at hand ready for use, by relating a case, which is re-recorded in his work on *Obstetrics*, in which the child cried within the vagina, while his forceps were sent for. The head was speedily withdrawn when he received the instrument, but too late to resuscitate the child. And his successor, the late Professor Ellerslie Wallace, always emphasized the importance of having the forceps at hand in such cases, and, indeed, in many cases of labor, and published a paper to enforce that view.*

*The American Journal Medical Sciences, July, 1870.

In the successful use of forceps, much depends not only on the skill of the operator, but also on the kind of instrument employed. There cannot be a doubt but that in delivering at or above the pelvic brim, or the upper two inches of the pelvic cavity, Tarnier's action-traction forceps possesses great advantages above all others. It has been many times demonstrated that an accurate adjustment of this forceps in the axis of the brim has accomplished the delivery of a living fœtus when previously craniotomy or a dead fœtus were the only alternative. (Here Dr. Howard exhibited a variety of forceps.)

In practice, in our days, the forceps or turning are usually rivals for choice with men equally skilled in both, when the conjugate of the brim of the pelvis varies from 3¼ to 3½ inches. The *pelvis equabiliter justo minor*, or uniformly contracted pelvis, calls for the forceps. Whether we can deliver or not depends greatly upon the position of the vertex. When the vertex is well flexed, the posterior fontanelle low in the line of the axis of the pelvis, while the anterior fontanelle is high up or unaccessible, the forceps may be used successfully. But when the anterior fontanelle is on a level with, or below the posterior, and the sagittal suture traverses the transverse diameter of the brim, the pelvis is almost sure to be flattened, and early version gives both mother and child the best chance for life.

There are many cases in which version at the brim, or below it, are far from being simple and easy. When the waters have been long discharged, and the uterus lashed into fury by long and violent efforts to expel the fœtus, and strongly contracted in spite of profound anæsthesia, version ranks among the most difficult obstetrical operations. Under such circumstances Dr. H. has seen three physicians, one after another, have their hands temporarily paralyzed and powerless, and when delivery was finally accomplished, the poor woman died. Dr. H. has also seen able obstetricians in such cases, fail to deliver at all. In a case of *placenta prævia*, and the hemorrhage copious and alarming, Dr. H. would not hesitate to turn at once, as soon as the hand could readily enter the uterus. But if dilatation could not be readily effected enough to permit the passage of the hand, Dr. H. would quickly apply the forceps. In cases of violent eclampsia, Dr. H. much prefers the forceps, especially in primiparæ, and have often succeeded in such cases in saving the lives of both mother and child by introduction of the forceps into the uterus. In such cases, it is easy to apply forceps with narrow blades, as Sir James Y. Simpson's forceps such as he used, when it is impossible to apply forceps with wider blades. And Tarnier's last model is preferable to those he formerly used, because in oblique applications the convexity of the old perineal curves comes into contact with one of the ischio-pubic rami and causes a deviation of the handle of the instrument, the action

of which then becomes defective, and tractions made upon the forceps are not directed according to the median plane of the body.

Dr. Miltenberger, in conclusion said that in private practice he had never lost a child by version. That the statistics he had read were made from hospital cases. He still maintained that a child could not be delivered by forceps more quickly than by version and at the same time with equal safety.

THE BRITISH GYNÆCOLOGICAL SOCIETY.

Meeting of October 14, 1885.

The President, ALFRED MEADOWS, M.D., F.R.C.P., in the Chair.

SPECIMENS.

Dr. Fancourt Barnes showed a large condyloma removed from the right nympha.

Dr. Edis showed a myoma he had removed, and which had been mistaken for cancer.

Dr Heywood Smith exhibited the ovaries he had semoved from a patient suffering from profuse hemorrhagia.

Dr. Bantock showed a ruptured papillomatous cyst of the right ovary which he had removed from a patient aged 36.

A NEW OPERATION FOR RUPTURED PERINÆUM.

Dr. Jamison, of Shanghai, read a paper on a case in which he performed a new operation. The lesion in the case described had existed for seventeen years, involving the lowest portion of the anterior wall of the rectum. The borders of the laceration had long since been completely absorbed, leaving no salient edges to be denuded and approximated. The patient was rendered unfit for society by total lack of control over the escape of flatus. There was partial incontinence of urine and fæces. Rectocele existed to a slight extent, and, during a recent labor, danger had arisen from a temporary cystocele. The operation proved completely successful in removing all the inconveniences enumerated, abstraction being made of what might possibly present itself should pregnancy again occur. It consisted in lifting the altered vaginal mucous membrane, along with the skin of the upper inner surface of the thigh corresponding to the sides of the vulvar opening, from the subjacent tissues, forming with them a new posterior vaginal wall; and raising cutaneous flaps from the ischio-rectal region, which were folded outward on themselves, and their denuded surfaces subcutaneously united in the middle line.

Dr. Fancourt Barnes thought the proceeding described by Dr. Jamison consisted essentially in the splitting of the recto-vaginal septum,

which was the main factor in Lawson Tait's operation. Since last May he had done Lawson Tait's operation nine times, and preferred it to the old operation of dissecting off mucous membrane. It was an improvement in every respect.

Dr. Imlach (Liverpool) said there were many ways of performing perinæorrhaphy. The point in placing the suture was to avoid tension. The perineal body, as a pelvic support, was useless, and therefore the operation was not necessary in all cases, unless the sphincter were torn.

Dr. Bantock agreed that the use of powerful sutures for the deep stitches was unnecessary. The operation, as practiced by him, was not a painful one. He could not accept Dr. Imlach's view as to the non-existence of a perineal body.

Mr. Lawson Tait acknowledged the remarks made by Dr. Fancourt Barnes on his operation. By his operation no tissue was removed, and the patient had a much larger, more solid and better sustained perinæum than could be obtained in any other way. Further, as the operation merely placed the parts in the condition in which they were at the time of the tear, repair necessarily took the most natural form, by the simple process of slitting the septum in the direction of the original cicatrix. He differed from the views of Dr. Imlach from beginning to end.

Dr. Edis also bore testimony to the advantage of Mr. Lawson Tait's method of operating. He had performed the operation.

Dr. Heywood Smith agreed as to the rapidity and success of the new operation. He invariably operated by that method.

Dr. Robert Barnes wished to remind the Society that Charles Brooke was one of the first to perfect a successful proceeding. He prepared the surfaces by denudation, and brought them together by silk sutures, and kept them so by his beads. The design of the beads was to secure adaptation of the deep or middle part of the wound. To secure the edges he sometimes put superficial sutures on the skin and to the mucous membrane in the vagina. Mr. Brooke had also worked out a successful treatment of vesico-vaginal fistula, having designed and made his own instruments, by one of which he could tie a knot at the fundus of the vagina at a distance of several inches from his fingers, without the use of a speculum.

For Bites of Insects.—Prof. Bartholow recommends permanganate of potash for bites of insects. The pain of an insect sting is due to an acid which any alkali will neutralize; hence ammonia is a good application.

For Constipation in Young Children.—Dr. Poulain, in the *British Med. Journal*, extols the use of a tablespoonful of fine bran night and morning, in a cup of bread and milk. The bran is warmed in the milk and then poured on the bread.

Abstracts and Selections.

I. — OBSTETRIC.

Displaced Spleen and Pregnancy.—Much attention has recently been paid to the anatomical or teratological condition of the kidney or liver when found to be unusually movable. Arguments have been brought forward to show that the condition represents a mere anatomical or physiological peculiarity, or, on the other hand, that it is pathological, and of the nature of hernia. The later theory is adopted by Landau and others, who also deem pendulous abdomen and uterine displacements to lie within the province of hernia. Dr. Gabriel Engel, of Klausenburg, Transylvania, has published in the *Orvos Természettudomanyi Ertesito*, a paper on the "Ætiology of Displaced Spleen." In three cases under his observation, two occurred in pregnant women, without interfering either with gestation or labor. The third case was very interesting. A woman suffered from amenorrhœa for sixteen months, and pregnancy had been confidently diagnosed, the patient, cachectic from malaria, had also been seized with acute pains resembling those felt during labor. A large soft tumor filled the lower part of the abdomen and the pelvis. Quinine was administered in all three cases, and the tumors diminished in size. Otherwise, should drugs or an abdominal belt have failed to relieve, Dr. Engel would have recommended extirpation in preference to the artificial induction of atrophy of the spleen by twisting that organ by manipulation applied to the abdominal walls, so as to cause the obstruction of the vessels at the hilum. Dr. Engel distinguished between displacement and mere enlargement, although the three cases which he quotes seem, from the satisfactory thereapeutic results to have all been instances of ague-cake. From any point of view it is doubtful if displaced spleen be homologous, pathologically speaking, to movable liver or kidney.—*British Medical Journal.*

Vomiting of Pregnaney treated by Artificial Feeding.—Dr. Brünniche reports in the *Hospitals-Tidende*, No. 29, 1885, the case of a pregnant woman who suffered from uncontrollable vomiting. After trying many things without success, the author obtained a cure by feeding his patient through a tube introduced through the œsophagus, but not into the stomach. Milk, broth, powdered beef, and other materials were introduced in this way and retained on the stomach, but as soon as the patient attempted to swallow the vomiting began again. At the end of three weeks, however, the vomiting was permanently controlled, and the patient was able to take food in the ordinary way.

II.—GYNICIC.

The Prevention of Mammary Abscess. — Arthur W. Edis, M.D., M.R.C.P., contributed this article to the *British Medical Journal:*

Instances are not unfrequently met with where the function of lactation is not considered advisable, or, as in cases of syphilitic taint, marked tendency to phthisis, epilepsy, etc.; or where, from the child being still-born, or the nipples depressed, subject to cracks, fissures or erosions, the function of lactation is unnecessary or unable to be persisted in. Apart from these conditions there is unquestionably a growing tendency among mothers to avoid the responsibility of suckling their offspring. Milk is secreted, and if it be not drawn off at appropriate intervals, the breasts become engorged and not infrequently inflamed, mammary abscess resulting. From whatever cause it may be, we are often obliged to take steps to prevent such a contingency.

For many years the oldfashioned methods in general vogue, if not advocated, were at least tacitly acquiesced in—such as rubbing the breasts with sweet oil; oil and extract of belladonna; glycerine and belladonna; belladonna plasters; evaporating lotions; strapping the breasts, and other like expedients.

It being believed that friction of any kind, in the large majority of cases, rather tended to produce than prevent mammary abscess, it was long since discarded. The application of a long strip of belladonna plaster, sixteen or eighteen inches long and six or eight inches deep, with round apertures so as to leave the nipples free, tightly across the chest, the breasts being brought well up toward the median line, for many years was the only resource adopted, beyond careful regulation of the diet, abstention from fluids, gentle purgation, etc. This method never failed, but it was found that the smell of the belladonna produced so much nausea in delicate patients as to preclude the employment of it.

Thinking that in all probability the pressure exerted contributed greatly to the advantage derived, I was induced to rely on a few turns of a rib-bandage, or the application of a thin towel or diaper across the chest, the breasts being brought well toward the sternum. Since adopting this method I have never known it to fail. Not a single instance of mammary abscess has occurred in a long series of cases extending over several years. The only precaution requisite is to apply the pressure on the second day following parturition, before the breast begins to fill, and to see that the whole of the glands are included.

It is well to elevate the shoulders somewhat more than usual, and not to allow the bedclothes to cover the upper part of the chest, the sheet alone sufficing to prevent any risk of chill. Restriction as to the amount of fluid for the first few days, and attention to the bowels is all that is requisite to insure success. Some little inconvenience, a feeling of tight-

ness or burning pain, is often experienced, but if the pressure be maintained, no harm results, and in the course of a few days the turgescence subsides and the difficulty is at an end.

In order to keep the bandage from slipping down, a shoulder-strap from back to front or merely pinning the bandage to the night dress suffices.

When the secretion of milk seems to be unusually abundant a mixture of bromide and iodide of potassium may be prescribed with benefit. In only a very few instances has it been found necessary to draw off a small quantity of milk by means of a breast pump or exhausted soda-water bottle, and this only once or twice.

I venture to think these remarks may prove of value to many, as I not unfrequently see instances of mammary abscess brought on, I verily believe, by the old fashioned method of rubbing and irritating the breasts.

[In the following number of the same journal, Dr. Philip Miall sends as an addition to the above the following:]

A method of treating inflamed breasts after delivery may be worth notice in connection with Dr. Edis paper on the use of support by a bandage or towel. Dr. Edis appears to use his method after every delivery, and by beginning it before lactation is established assures success; but one occasionally sees cases where abscess is on the point of forming, either from neglect or injudicious treatment, and where, consequently, something more is required.

I have repeatedly seen a hot, heavy, inflamed breast, with redness of skin, throbbing, and deep seated pain, the pulse being 120 in the minute, yet these symptoms have disappeared in the course of a few hours under solutions of hot water and ammonia. An ounce of carbonate of ammonia is dissolved in a pint of boiling water, and when solution is effected the temperature will scarcely be too high for fomentation with cloths dipped in the liquid. These must be assiduously applied for half an hour at least, and repeate l two or three hours later if necessary. It is well to protect the nipples, though I have never known them to be injured. Relief is immediate, and more than three applications are seldom required.

Unless applied too late or improperly, or some foolish rubbing or drawing with the breast pump be used contrary to orders, this remedy may be thoroughly relied on. I am indebted for it to Mr. Douglas, of Banbury, and as it has had a trial of thirty years in my hands I can speak of it with some confidence.

An Historical Instance of Alleged Late Menstruation.—Probably there is no more striking illustration of the truth that a man is incapable of judging alleged facts belonging to a department of knowledge which he has

never studied, says the *Medical News*, than was given by Gibbon in regard to the death of Asima, the mother of Abdallah. The statement referred to is found in a note to the fifty-sixth chapter of "Decline and Fall of the Roman Empire." Abdallah had for months successfully sustained the seige of Mecca, but was finally compelled to yield, the city was taken, and he was slain. The tidings of his death were borne to Asima, and Gibbon states as a "physical effect of her grief for his death, the return at the age of ninety, and fatal consequences of her *menses*." The authority from whom Gibbon seems to have derived this remarkable statement was D'Herbelot; and, upon referring to his great work "Bibliothèque Orientele," 1777, it is found that this author not only asserts the return of menstruation in Asima in consequence of the profound emotion caused by her son's death, but that the flow proved fatal in five days.

Our contemporary remarks that a knowledge of human physiology would have saved Gibbon from accepting as a fact so marked a violation of physiological law. Such a flow as occurred in Asima's case was in no proper sense to be set down as menstruation—the very fact of its proving fatal would be an obvious objection, apart from any other, to accepting such view.

If so learned a man as Gibbon, one so little disposed to be credulous that he often leaned to credulity, could repeat that which every intelligent physician would reject, it is not astonishing that the ignorant will accept the most absurd statements in regard to medical matters, and are so frequently made the prey of designing quacks. The narrative too, has a wider application, as indicated at the beginning of the note.—*Boston Med. and Surg. Journal.*

Lawson Tait says: "The amount of worry which is given him by every case of hysterectomy, even when successful, is such as to be almost beyond the recompense of any fee; and the disappointment inflicted by every death is quite indescribable."

The Obstetric Gazette and Cincinnati *Lancet and Clinic* to one address, one year, $5.00.

Bibliography.

The Medical News Visiting List. 1886.—Philadelphia: Lea Bros. & Co.

This is a new candidate for favor in this line, and certainly the most attractive in all its features and make-up of anything we have seen. The visiting pages are ruled for thirty patients each week, besides which we have a great variety of convenient additions. Thus: Examination of

Urine; Disinfectants; Occasional Remedies; Table of Doses; something new—A Therapeutic Table, most capital as a guide. Then we have space for Clinical Reports; Consultation; etc., etc. The mechanical execution is very fine, and the book is sold at $1.00, but to paying subscribers to the *Medical News* or *Am. Journal of Med. Science* it is 75 cts. This is cheap and good.

Manual of the Diseases of Women.—Being a Concise and Systematic Exposition of the Theory and Practice of Gynecology. For the use of Students and Practitioners. By CHARLES H. MAY, M. D., Late House-Physician, Mt. Sinai Hospital, New York, etc. Philadelphia: Lea Brothers & Co., 1885.

Books devoted to gynecology are numerous, indeed, growing upon us; the present volume does not presume to be a fresh or exhaustive work, but rather, a condensed resumè of the works of others. Indeed, the author very modestly states in his preface, that his book is "chiefly a *compilation*," and proposes to give the views of the leading authorities, as Emmet, Thomas, Mundè, and others.

This work is very well done, and will prove convenient as a handbook of references; the important operations are explained very clearly, and the whole subject is given in convenient shape. As a manual the book may be regarded as a success.

Epilepsy and Other Chronic Convulsive Diseases:—Their Causes, Symptoms, and Treatment. By W. R. GOWERS, M. D., F.R.C.P., etc. New York: Wm. Wood & Co., 1885.

This is the September volume of *Wood's Library*. A most excellent and exhaustive treatise on the subject; indeed, it would be difficult to find a place for criticism.

On Renal and Urinary Affections.—By W. HOWSHIP DICKINSON, M. D., Cantab., F.R.C.P., etc. Miscellaneous Affections of the Kidneys and Urine. New York: Wm. Wood & Co., 1885.

This is another very excellent, as well as timely, volume in the series of *Wood's Medical Library*—the series for 1885. In the series for 1881, of this library, the same author gives a volume on *Albumenuria*. This volume may very well be considered a supplement to that, and the whole is a very complete study of the diseases of the kidneys. As usual, each of these volumes is well printed, and all the publisher's work is well done. We can heartily commend these continued series of the *Wood's Library* as the cheapest and best additions the doctor can make to his library, and even then he will have but little spare time to keep up his reading.

The whole subject—epilepsy, in all its forms and causes—is fully treated. Chapter xiii is devoted to the *treatment*, and the fact that over twenty remedies and various dietary and other plans of treatment are presented is a sufficient evidence that satisfactory methods are not yet arrived at. But the student of these epileptic troubles will find in this book all that is thus far known, and all the plans that are of value.

Poisons, their Effects and Detection.—A Manual for the use of Analytical Chemists and Experts; with an Introductory Essay on the Growth of Modern Toxicology. By ALEXANDER WYNTON BLYTH, M.R.C.S., etc. With Tables and Illustrations. Vol. II. New York: Wm. Wood & Co., 56–58 Lafayette Place; 1885.

PART I. of this valuable and complete work was issued as the June volume of the *Medical Library*, and was noticed at that time. This volume completes the work on poisons. We have but little to say in addition to what was said upon the issue of the first volume. The whole subject is thoroughly treated, and the general prcctitioner who wants a ready reference will find these two volumes most reliable authority.

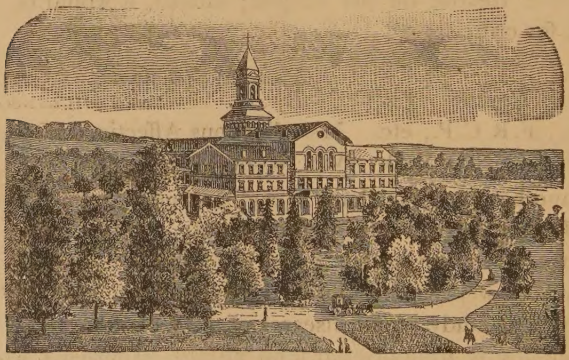
E. B. S.

OXFORD RETREAT.

OXFORD, OHIO.

D. A. MORSE, M.D., Superintendent.

THE RETREAT is a private Institution for the treatment of all forms of Nervous and Mental Diseases, including Epilepsy, select cases of Inebriety, the Opium Habit, and Nervous Disorders of Children.



THE RETREAT, now in successful operation, is extensive (over 100 rooms), well arranged, well fitted and furnished, with beautiful grounds (35 acres), and every facility desired; vapor, medicated and electric baths. Morphine cases treated with little suffering and inconvenience. Select cases of inebriety received. Separate apartments for different forms of disease. Incurable cases cared for by the year at reduced rates. Special attendants furnished if desired. Regular night as well as day attendants for epileptics and others requiring it. The first floor is reserved for nervous disorders.

THE RETREAT IS ENDORSED BY THE PROFESSION.